# Rocky Mountain Medical Journal

*Title Registered, U. S. Patent Office*

**Publication Office**
835 Republic Building, (1612 Tremont Place), Denver 2, Colorado
Telephone AComa 2-0547

**EDITORIAL BOARD**

**Colorado:** Douglas W. Macomber, M.D., Scientific Editor, 1800 High St., Denver; Lyman W. Mason, M.D., Associate Editor, 1214 Republic Bldg., Denver (Chairman of Editorial Board).

**Montana:** Raymond F. Peterson, M.D., Scientific Editor, 9 W. Granite St., Butte; L. Russell Hegland, Associate Editor, 1236 N. 28th Street Billings.

**New Mexico:** Carl H. Gellenthien, M.D., Scientific Editor, Valmora, New Mexico; Ralph R. Marshall, Associate Editor, 223-4 First National Bank Bldg., Albuquerque.

**Utah:** Richard P. Middleton, M.D., Scientific Editor, Boston Bldg., Salt Lake City; Harold Bowman, Associate Editor, 42 South Fifth East St., Salt Lake City.

**Wyoming:** Franklin D. Yoder, M.D., Scientific Editor, State Office Building, Cheyenne; Arthur R. Abbey, Associate Editor, P. O. Box 1252, Cheyenne.

**Managing Editor:** Harvey T. Sethman, 835 Republic Bldg., Denver.

**Ownership and Sponsorship:** The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a nonprofit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Colorado State Medical Society, the Montana Medical Association, the New Mexico Medical Society, Utah State Medical Association, the Wyoming State Medical Society, the Rocky Mountain Medical Conference, and the Colorado Hospital Association.

**Manuscripts:** Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

**Advertising:** National representatives: The State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Ill. Local advertising from firms in the Rocky Mountain area should be submitted to the Associate Editor of the appropriate state or to the Journal office. Advertising forms close on the 15th of the month preceding publication; allow ten days additional to insure submitting proofs for approval.

**Subscription:** $3.50 per year in advance, postpaid in the United States and its possessions; single copy 35c plus postage. Subscription is included in medical society dues of sponsoring state medical organizations.

**Copyright:** This Journal is copyright, 1956, by the Colorado State Medical Society. Requests for permission to reproduce anything from the columns of this Journal should be addressed to the Journal Office.

**Second Class Matter:** Entered as second class matter Jan. 22, 1906, at the Post Office at Denver, Colo., under the Act of Congress of March 3, 1879. Accepted for mailing at special rates of postage provided for in Section 1103, Act of Oct. 3, 1917; authorized July 17, 1918.

# Table of Contents

**VOLUME 53** **JUNE, 1956** **NUMBER 6**

# Rocky Mountain Medical Journal

*Title Registered, U. S. Patent Office*

**Publication Office**
835 Republic Building, (1612 Tremont Place), Denver 2, Colorado
Telephone AComa 2-0547

**EDITORIAL BOARD**

**Colorado:** Douglas W. Macomber, M.D., Scientific Editor, 1800 High St., Denver; Lyman W. Mason, M.D., Associate Editor, 1214 Republic Bldg., Denver (Chairman of Editorial Board).

**Montana:** Raymond F. Peterson, M.D., Scientific Editor, 9 W. Granite St., Butte; L. Russell Hegland, Associate Editor, 1236 N. 28th Street Billings.

**New Mexico:** Carl H. Gellenthien, M.D., Scientific Editor, Valmora, New Mexico; Ralph R. Marshall, Associate Editor, 223-4 First National Bank Bldg., Albuquerque.

**Utah:** Richard P. Middleton, M.D., Scientific Editor, Boston Bldg., Salt Lake City; Harold Bowman, Associate Editor, 42 South Fifth East St., Salt Lake City.

**Wyoming:** Franklin D. Yoder, M.D., Scientific Editor, State Office Building, Cheyenne; Arthur R. Abbey, Associate Editor, P. O. Box 1252, Cheyenne.

**Managing Editor:** Harvey T. Sethman, 835 Republic Bldg., Denver.

**Ownership and Sponsorship:** The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a nonprofit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Colorado State Medical Society, the Montana Medical Association, the New Mexico Medical Society, Utah State Medical Association, the Wyoming State Medical Society, the Rocky Mountain Medical Conference, and the Colorado Hospital Association.

**Manuscripts:** Scientific Articles, Case Reports, etc., from any state for which this is the Official Journal should be submitted to the Scientific Editor for that state as named in the Editorial Board, above. Other material from any participating state should be submitted to the Associate Editor for that state as named above. Manuscripts from outside the Rocky Mountain area should be sent direct to the Journal office. Manuscripts must be typewritten, double or triple spaced, using only one side of each sheet. It is the policy of this Journal to omit bibliographies.

**Advertising:** National representatives: The State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Ill. Local advertising from firms in the Rocky Mountain area should be submitted to the Associate Editor of the appropriate state or to the Journal office. Advertising forms close on the 15th of the month preceding publication; allow ten days additional to insure submitting proofs for approval.

**Subscription:** $3.50 per year in advance, postpaid in the United States and its possessions; single copy 35c plus postage. Subscription is included in medical society dues of sponsoring state medical organizations.

**Copyright:** This Journal is copyright, 1956, by the Colorado State Medical Society. Requests for permission to reproduce anything from the columns of this Journal should be addressed to the Journal Office.

**Second Class Matter:** Entered as second class matter Jan. 22, 1906, at the Post Office at Denver, Colo., under the Act of Congress of March 3, 1879. Accepted for mailing at special rates of postage provided for in Section 1103, Act of Oct. 3, 1917; authorized July 17, 1918.

# Table of Contents

**VOLUME 53** **JUNE, 1956** **NUMBER 6**

your patient should not be endangered by fluid accumulation during "rest periods"

YOUR PATIENT NEEDS AN ORGANOMERCURIAL

When a diuretic must evoke acidosis to be effective, continued administration without dosage limitation results in refractoriness. Other diuretics may require interrupted dosage to avoid gastro-intestinal irritation.

But the sustained diuresis achieved by the organomercurials never necessitates routine "rest periods" because of their mode of action.

TABLET **NEOHYDRIN®**

BRAND OF CHLORMERODRIN (10.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure **MERCUHYDRIN® SODIUM**
BRAND OF MERALLURIDE INJECTION

01284

LAKESIDE

# Now, for only $4950* G. E. brings you complete 200-ma x-ray facilities

*f.o.b. Milwaukee, U.S.A.



**New PATRICIAN diagnostic unit** — the low-cost x-ray unit with major features you've always wanted. You get 81-inch angulating table • independent tube stand with choice of floor-to-ceiling or platform mounting • 200 ma-100 kvp, full-wave transformer and control • double-focus, rotating-anode tube. But that's not all.

You're equipped for vertical and horizontal radiography — Bucky and non-Bucky technics —even cross-table and stereo views. Focal-film distances up to full 40 inches at any table angle . . . as great as 48 inches cross-table.

The new PATRICIAN features a counterbalanced fluoroscopic unit with full screening coverage. Even the new automatic reciprocating Bucky is counterbalanced — self-retaining in all table positions.

Contact your General Electric x-ray representative for details or demonstration, and be sure to have him explain the G-E Maxiservice® *rental* plan.

*Progress Is Our Most Important Product*

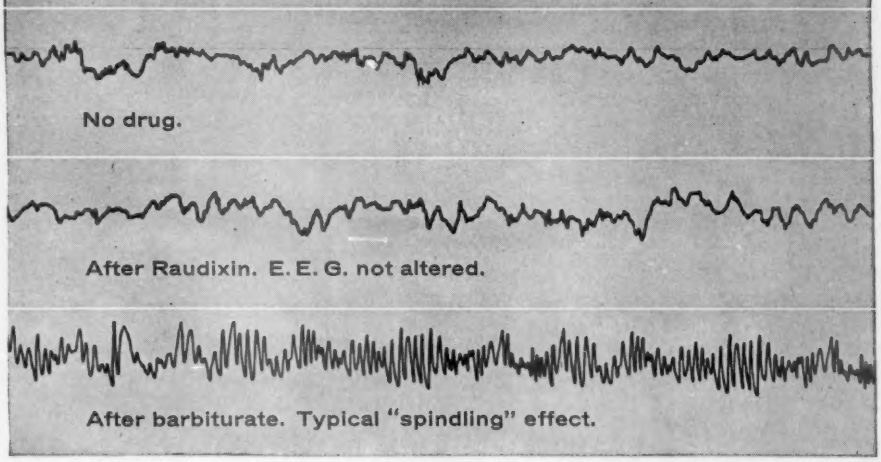
GENERAL ELECTRIC

*Direct Factory Branches:*
DENVER — 1338 Glenarm Place
SALT LAKE CITY — 215 South 4th St., East

*Resident Representatives:*
COLORADO SPRINGS — I. S. Price, 1532 N. Royer Ave.
BUTTE — J. E. Pixton, 103 No. Wyoming St.

# WHAT IS THE DIFFERENCE BETWEEN A TRANQUILIZER AND A SEDATIVE?

*Comparison of the effect of Raudixin (tranquilizer) and a barbiturate (sedative) on the cortical electroencephalogram*




Because barbiturates and other sedatives depress the cerebral cortex, the sedation achieved is accompanied by a reduction in mental alertness.

Raudixin acts in the area of the midbrain and diencephalon, and does not depress the cerebral cortex. Consequently, the tranquilizing (ataractic) effect achieved is generally free of loss of alertness.

## RAUDIXIN

Squibb Whole Root Rauwolfia Serpentina

DOSAGE: 100 mg. b.i.d. initially; may be adjusted within a range of 50 mg. to 500 mg. daily. Most patients can be adequately maintained on 100 mg. to 200 mg. per day.

SUPPLY: 50 mg. and 100 mg. tablets; bottles of 100, 1000 and 5000.

SQUIBB

*Squibb Quality—the Priceless Ingredient*

*RAUDIXIN® IS A SQUIBB TRADEMARK

# "Taste Appeal" for the Low-Fat, Low-Cholesterol Diet

**Palatability** is the key to planning this diet. And these flavor tips will help you keep in the "taste appeal" your patient must have and still keep out the rich foods he cannot have.

### *These are for flavor—*

Cranberry and tomato sauce pinch-hit for gravy. Fruit juices are to baste with as well as to drink. And herbs and spices lend a fine aroma to meats and vegetables.

### *Here's where they go—*

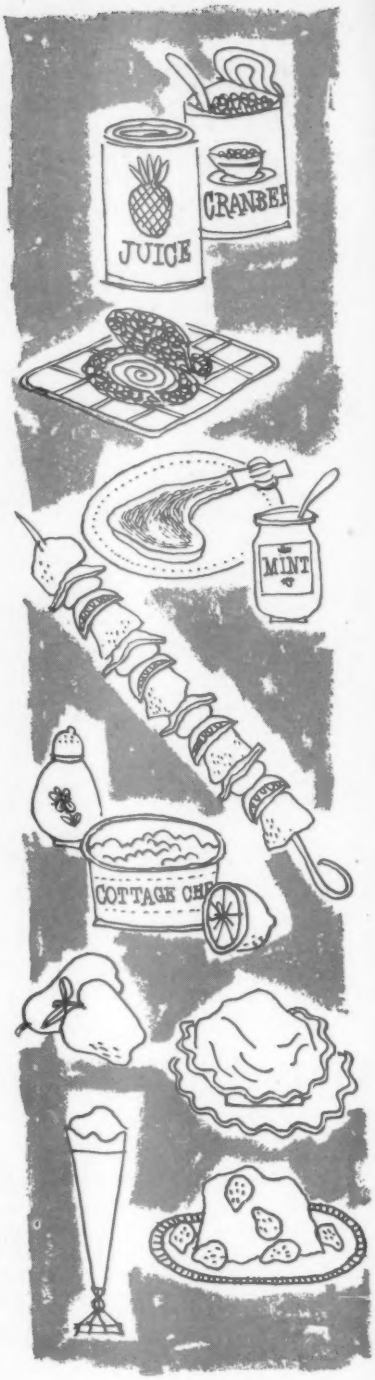
Meat loaf can sport a gay cap of whole-cranberry sauce, while hamburgers make a surprise party when a slice of pickle or onion is sealed between two thin patties. Your patient can baste chicken with lemon or orange juice—glaze lamb chops with mint jelly. Lean meats, broiled or baked, are made savory with herbs. And barbecued kabobs add something different.

Most vegetables can be dressed simply with lemon juice or an herb vinegar. And tomato halves broil nicely with brown sugar and sweet basil on top.

On green salads, cottage cheese thinned with lemon juice, sparked with paprika, makes the dressing. And on fruits, try lemon juice, honey and chopped mint.

For dessert, angel cake or meringue shells go nicely under fruits—skim milk powder makes the "whipped cream." Snow pudding is a simple dessert—fresh fruit, even more so. And for a change, your patient may like his fruit baked in grape or cranberry juice.

The diet, of course, will be balanced nutritionally at a suitable calorie level. And these "diet do's"—plus an occasional glass of beer*, if you permit—will help keep your patient happy within the limits you set for his diet.




**United States Brewers Foundation**

***Beer—America's Beverage of Moderation***

*Fat—0; Calories 104/8 oz. glass (Average of American Beers

**If you'd like reprints for your patients, please write United States Brewers Foundation, 535 Fifth Avenue, New York 16, N. Y.**

# BON VOYAGE BEGINS WITH BONAMINE*

BRAND OF MECLIZINE HYDROCHLORIDE

**longest-acting motion-sickness remedy**[1] effective in low dosage . . . controls motion sensitivity symptoms in minutes . . . one dose usually prevents motion sickness for 24 hours.

**In recommended dosage Bonamine is notably free from side reactions** . . . supplied as: BONAMINE TABLETS, scored, tasteless, 25 mg. . . . BONAMINE CHEWING TABLETS, pleasantly mint flavored, 25 mg.

*Trademark 1. Report of Study by Army, Navy, Air Force Motion Sickness Team: J.A.M.A. 160:755 (March 3) 1956.

Pfizer PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.

# KARO® SYRUP...meets all the criteria for effective milk modification

Because Karo Syrup is a balanced fluid mixture of dextrins, maltose, and dextrose, it is well tolerated, easily digested and completely utilized. Its use will not induce flatulence, colic, fermentation or allergy.

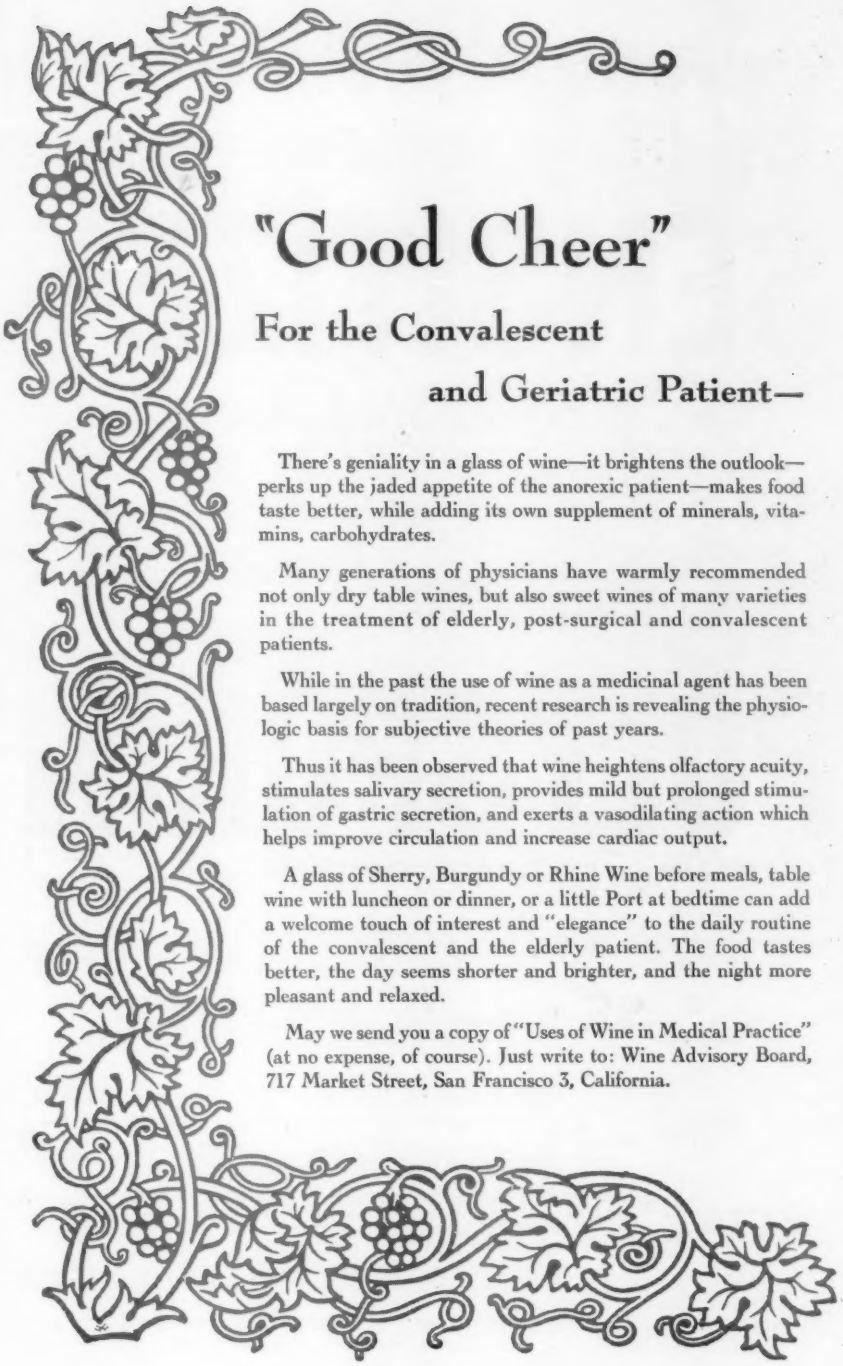
Obviously, the selection of a milk modifier for infant feeding depends to a large extent upon the needs of the individual infant. But, after three generations of use, Karo is still a carbohydrate modifier of choice for *all* infants.

From the standpoint of the physician, Karo permits easy adjustment of formula and safe transition from liquid to solid food as circumstances demand.

Mothers appreciate the fact that Karo is readily available, inexpensive and easy to use.

Light or dark Karo Syrup may be used interchangeably, with cow's milk or evaporated milk and water. Each tablespoonful yields 60 calories.


1906 • 50th ANNIVERSARY • 1956
CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.



# "Good Cheer"

## For the Convalescent and Geriatric Patient—

There's geniality in a glass of wine—it brightens the outlook—perks up the jaded appetite of the anorexic patient—makes food taste better, while adding its own supplement of minerals, vitamins, carbohydrates.

Many generations of physicians have warmly recommended not only dry table wines, but also sweet wines of many varieties in the treatment of elderly, post-surgical and convalescent patients.

While in the past the use of wine as a medicinal agent has been based largely on tradition, recent research is revealing the physiologic basis for subjective theories of past years.

Thus it has been observed that wine heightens olfactory acuity, stimulates salivary secretion, provides mild but prolonged stimulation of gastric secretion, and exerts a vasodilating action which helps improve circulation and increase cardiac output.

A glass of Sherry, Burgundy or Rhine Wine before meals, table wine with luncheon or dinner, or a little Port at bedtime can add a welcome touch of interest and "elegance" to the daily routine of the convalescent and the elderly patient. The food tastes better, the day seems shorter and brighter, and the night more pleasant and relaxed.

May we send you a copy of "Uses of Wine in Medical Practice" (at no expense, of course). Just write to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

# WHY SENSITIZE

*in topical and ophthalmic infections*

# USE 'POLYSPORIN'®

brand

**POLYMYXIN B—BACITRACIN OINTMENT**

*to insure broad-spectrum therapy with minimum allergenicity*

For topical use: in ½ oz. and 1 oz. tubes.
For ophthalmic use: in ⅛ oz. tubes.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

DOCTORS EVERYWHERE NOW KNOW WHY

# Viceroys Are Smoother


Professional men who have studied the microscopic analysis of the Viceroy filter now know why the Viceroy taste is smoother—never rough. Only Viceroy has 20,000 tiny filters in every tip—twice as many filters as the other two largest-selling filter brands. That is why Viceroys are smoother by far—never, never rough. That is why so many doctors now smoke and recommend Viceroys.

**Yes, smoother taste because there are**

**TWICE AS MANY FILTERS IN EVERY VICEROY TIP**

**as the other two largest-selling filter brands!**


Viceroy's exclusive filter is made from pure cellulose—soft, snow-white, natural!

magnified potency
with Meti-steroid
effectiveness in allergic
and inflammatory dermatoses

new

# Meti-Derm cream 0.5%

with METICORTELONE, original brand of prednisolone

- *approximately*
*twice the per milligram*
*anti-inflammatory activity*
*of topical hydrocortisone*
- *cosmetically acceptable*
- *water-washable*

**for effective local relief** of allergic (atopic and contact) dermatoses, nonspecific anogenital pruritus.

**formula:** Each gram of water-washable METI-DERM Cream contains 5 mg. (0.5%) of prednisolone, free alcohol, in a cosmetically acceptable base.

**packaging:** METI-DERM Cream, 0.5%, 10 Gm. tube.

METI-DERM,* brand of prednisolone topical.
METICORTELONE,® brand of prednisolone.
*T.M.

...and adding dual control

to Meti-steroid skin therapy—

protection

against infection

new

# Meti-Derm ointment

with Neomycin

*enhanced effectiveness*

*in allergic, inflammatory*

*dermatoses when*

*minor infection*

*is present*

*or anticipated*

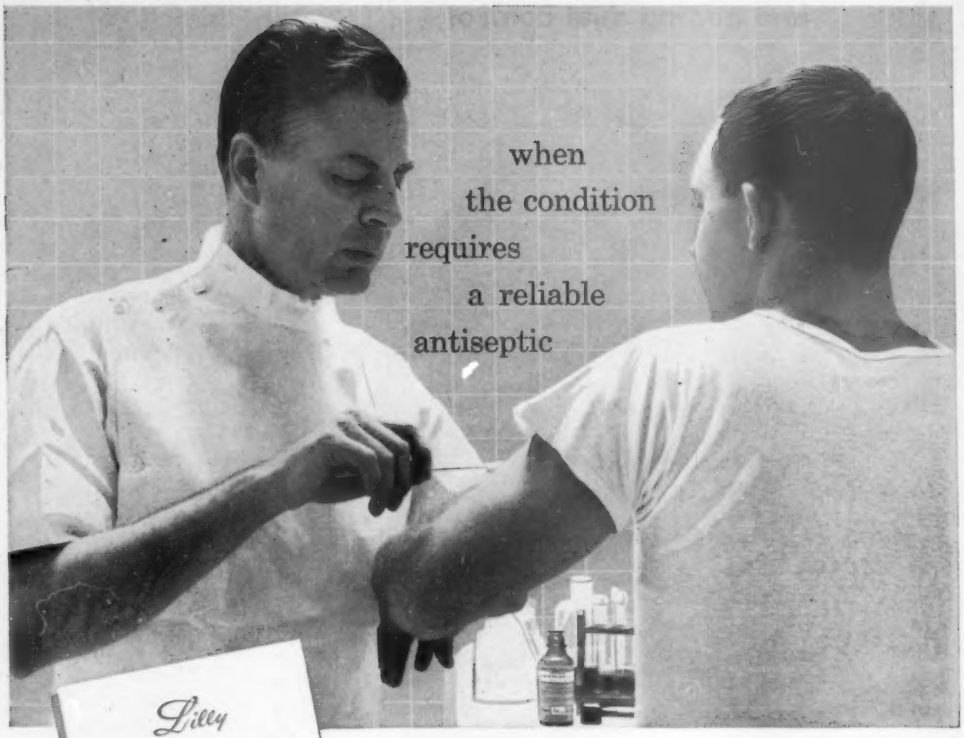

**neomycin in addition to prednisolone, free alcohol**
—for protective coverage against virtually all pathogenic skin bacteria with a well-tolerated, *topical* antibiotic.

**formula:** Each gram of water-washable METI-DERM Ointment with Neomycin contains 5 mg. (0.5%) prednisolone, and 5 mg. (0.5%) neomycin sulfate equivalent to 3.5 mg. neomycin base.

**packaging:** METI-DERM Ointment with Neomycin, 10 Gm. tube.

Schering

MD-J-656




specify

# 'Merthiolate'

(THIMEROSAL, LILLY)

*'Merthiolate' is highly active under virtually all conditions; is relatively nonirritating and nontoxic*

'Merthiolate' is germicidal in dilutions up to 1:4,000 in serum media and is relatively nonirritating in the concentrations suggested for use. It also maintains its activity in the presence of soaps. The fact that 'Merthiolate' is used as a bacteriostatic agent in fluids for parenteral administration gives strong evidence of its safety.

ELI LILLY AND COMPANY

80TH ANNIVERSARY 1876 • 1956

# EDITORIALS

## *Antisepsis in Open Wounds*

RESPECT for open wounds is reflected in gentle handling, fine instruments, and lightweight suture material. Students are taught to avoid further damage to tissues already afflicted with trauma. Bacteria inevitably present may be washed away before they have time to invade; if they are washed away, they need not be killed by some antiseptic substance capable of also injuring tissue cells. These are basic facts.

A colleague has written to the A.M.A. with a question which has been answered in the section "Queries and Minor Notes" of the Journal. The question reads, "What is the accepted opinion on the use of tincture of merthiolate as adjunct treatment of abrasions and lacerations of the skin? Is the tissue destruction resulting from its presence in a wound of a sufficient amount to contraindicate its use as an antiseptic or a germicidal agent? Is there any clinical evidence to support a claim that greater risk of wound infection or delayed healing would result if tincture of merthiolate were to be applied to a laceration already prepared by debridement and the use of a good detergent prior to suturing?" The answer is interesting. It comments upon the oft-repeated denial that organic mercurial antiseptics possess any high germicidal value, and that test tube conditions differ from wounds and skin surfaces. In some instances, alcohol alone has been more effective than the same alcohol containing a mercurial disinfectant. It is probable that certain tinctures actually do little damage to tissues unless presence of extraneous substances alter chemical composition. In any event, ample evidence regarding reduction of bacterial flora by application of antiseptics indicates that their effect is variable, disappointing, and unpredictable.

Let us be ever mindful of the simplest means of cleansing a wound in preparation for repair. Physiologically, normal saline solution is more compatible with tissues than is water. In fact, water is traumatic and painful in large wounds. Even upon compound brain injuries, soap and normal saline solution do only good—not harm. Why not tender all traumatic wounds the same respect?

## *Authors, Hear Ye!*

CLICHES in medical writing have received the gibes of our readers for years. Of all the words which are used and abused, ad nauseam, is the word "marked"; even more inane is its running mate "markedly."

Distraught colleagues sharing editorial responsibilities of State Medical Journals plead in self-defense against these two words. One Editor offers a list of synonyms, together with a prayer that they will be used again and again until finally in the future the cliches "marked" and "markedly" will never be heard again: "Great, copious, abundant, large, tangible, evident, perceptible, clear, unmistakable, decided, pronounced, distinct, appreciable, extreme, noticeable, prominent, conspicuous, outstanding, salient, and others."

With so many good words from which to choose, what sort of mental laziness has victimized those who express definite findings, signs, and symptoms by only one poor and senseless word? It is almost as absurd as the more generally abused term "by and large." Definition of the latter should defy the imagination of the most imaginative among writers and speakers. We would like to join our fellow editor in stating, "Let us take our hats off to the wag who suggests that what the world needs is not only a good five-cent cigar, but a set of new cliches as well."

## *Sunshine and Cutaneous Cancer*

AN ARTICLE of particular interest to physicians of the Rocky Mountain region appeared in a recent issue of the Wisconsin Medical Journal. It is entitled "Climate and Cutaneous Cancer," by Dr. David Goe Welton. The author quotes from a lecture by Dr. William F. Peterson of 1934, at which time Dr. Peterson was Professor of Pathology at the University of Illinois: "Meteorological environment has a great deal to do with the reaction of the human organism as it finds clinical expression in the inadequacies that we call diseases." Comment was made upon the primary interest of medicine being centered upon infectious diseases from the middle of the last century until about twenty years ago, when more attention started toward noninfectious diseases. These, of course, included the tumors.

Dr. Welton has been particularly impressed by the high incidence of skin cancer and its relationship to exposure to sunlight in North Carolina and the Southern states. For example, in Georgia there are six times as many epitheliomas in the white population as in the Detroit and Chicago areas. Though epitheliomas occur less often in women than in men, there are three times as many in the female population of the South as in the North. In various southern areas and in Denver, the most common primary site of all cancer is in the skin. In Fort Worth and Dallas, 50 per cent of all cancers in white males occur primarily in the skin, compared with 12.5 per cent in Chicago. Public Health Service surveys indicate that incidence of skin cancer parallels the number of hours of sunshine, but this is not the only factor. The average temperature is 40 per cent higher in New Orleans than in Chicago; therefore, people of New Orleans are exposed to many more hours of sunshine than people of Chicago. In the Carolinas are many persons whose forebears lived for generations on the British Isles. These people have fair and ruddy complexion, as do many whom we see in this section of the United States. Their skin does not tan and has little defense against carcinogenic ultraviolet radiation. Here, too, incidence of skin cancer is high.

The carcinogenic elements of sunlight are the ultraviolet rays in the range of 3,200 angstrom units and shorter, which comprise about 0.2 per cent of the sunlight. Laboratory workers have produced epitheliomas and other tumors by exposing laboratory animals to these wave lengths. Blum states, "Tumor growth is progressively accelerated by regularly repeated doses of ultraviolet radiation, the amount of acceleration being directly proportional to the dose." Sunlight is not responsible for all types of cutaneous cancer. For example, malignant melanomas usually occur on unexpected areas.

Dr. Welton summarizes all of the evidence he has collected as follows:

1. Ninety per cent of cancers of the skin occur on the hands and face.
2. Outdoor workers and others who are exposed to sunlight over a period of years are the most susceptible to this type of cancer.
3. Untravolet radiation with wavelengths present in sunlight induces cancer of the skin in mice and rats.
4. Skin cancer (in humans) is much more common in the Southern than in the Northern latitudes.
5. Persons who are relatively immune to sunburn, particularly Negroes, are less susceptible to skin cancer.

In conclusion Dr. Welton makes the philosophic deduction that astronomy directly or indirectly has much to do with health and the practice of medicine, for "with the seasons men's diseases, like their digestive organs, suffer change."

Those of us who practice in the higher altitudes where ultraviolet rays are not filtered out by dirt and "smog" are interested in this statistical evidence that prevalent rates of skin cancer are greatest here and in the Southern states. Many of our people make their living out-of-doors; and down South the populace spends more hours in the open. Whether or not we are particularly concerned with dermatoses or cutaneous tumors, let us remember to warn our outdoor patients to wear hats and gloves and to be temperate in worship of the sun. This small effort on our part will constitute a substantial bit to public health education and preventive medicine in the Rocky Mountain region.

# ARTICLES

## Common Eye Problems Encountered In General Practice*

James S. Shipman, M.D.
and Cyril M. Luce, M.D.
PHILADELPHIA, PENNSYLVANIA

OPHTHALMOLOGY occupies a unique, but somewhat peculiar, position in the armentarium of most general practitioners. More than in any other minor specialty which the general practitioner is called upon to practice, there has been a remarkable tendency to undertreat or overtreat the patient. The source of this difficulty rests not with the general practitioner, who is generally a member of a remarkably capable group of men, but with the *training* popular in the past several decades in our medical schools. As most of you remember from your medical school days, your eye training was indifferent, if not actually poor. There seems to have been two major reasons for this deficiency of training. First, clinical opthalmologists were called in to teach. These highly specialized men are generally out of touch with basic general medicine, and tend to make their lectures dull with too many details and highly technical approaches. Secondly, the students at the threshold of medicine tend to scorn the minor specialties and hold, as their ideals, medicine, pathology, physiology, and general surgery. As a result, eye lectures are often dull to both parties and unproductive of results. The general practitioner, consequently, tends either to disclaim all knowledge of eye diseases, or occasionally, to claim he knows more than he actually does. This situation confuses the patient, as he expects his family doctor to know something about everything. The general practitioner often will not attempt to treat a simple eye problem or, on the other hand, will treat a serious lesion that he had best refer. So ophthalmology often continues to be unsatisfactory to many general practitioners. We hope that better teaching methods will rectify this problem. In the meantime, most general practitioners probably encounter about 1 to 2 per cent eye patients in the total of their general practice. Some of you practicing in more remote areas of this State will be called upon to render more eye care than those in a more populated area. In general, it is more important to remember what not to do than what to do. The obvious reason is that a mistake in the treatment of the eye is immediately apparent to the patient and to his relatives, both in terms of cosmetic appearance and in reduction of vision which the patient himself can evaluate.

First, there are two segments of the population which are more likely to have ocular diseases, the young and the aged. In general, people 20 to 40 years of age are not likely to have serious eye disease, except for traumatic and inflammatory lesions. In infancy, many ocular lesions are missed because of inattention and difficulty of examination. Those of you who do your own obstetrics and pediatrics should perform at least a cursory examination of the infant's eyes. The orbits should be checked to observe that both globes are present, of equal size, cornea clear, pupillary space black, and conjunctiva pink. Congenital ocular defects noted by the general practitioner serve to inspire confidence in the parents' minds. It serves to show that their general practitioner is interested in all phases of their child's health.

In the first year of life certain ocular defects may be noted, most properly by the

*Presented before the annual meeting of the Utah State Medical Association at Salt Lake City, on September 8, 1955.

family doctor. Congenital defects again assume importance in the parents' minds. They like to be reassured that their child is "normal." The general practitioner should have a firm mental picture of the proper size of the globe so that he can be aware early of a small globe, microphthalmos, about which little can be done—and a large globe, congenital glaucoma, about which a great deal can be done in the early stages.

**Coloboma** of the eye is a relatively uncommon lesion, but most of you will have occasion to deal with one or more of its manifestations. The coloboma may involve the lid, causing a notched defect; the iris, causing a keyhole pupil; the lens; the ciliary body; the choroid; the retina; and the optic nerve. One or all of these structures may be affected in a given case. Except for plastic repair of the lid, there is no treatment available.

**Dermoid Cysts** are occasionally found by the mother. These are small tumors located beneath the upper lid near the outer canthus. The treatment consists of a careful dissection of the mass.

**Congenital Cataracts** are fairly common and may present a problem in differential diagnosis from other conditions which appear as a white mass behind the lens. Some of these will be mentioned later. It is well to remember that some congenital cataracts are compatible with fairly good vision, and that in general this type cataract is not progressive. You are all familiar with the numerous congenital defects that maternal rubella in the first trimester of pregnancy can cause, one of the defects being congential cataract.

**Retinoblastoma** or **Glioma** is one of the most distressing of all congenital diseases. This tumor is usually considered to be present at birth or shortly after; however, it may occur later. It causes the white pupil, usually first noted by the mother. The only treatment is enucleation and observation of the remaining eye, as the tumor is bilateral in 25 per cent of the cases, and is fatal unless the eye is removed.

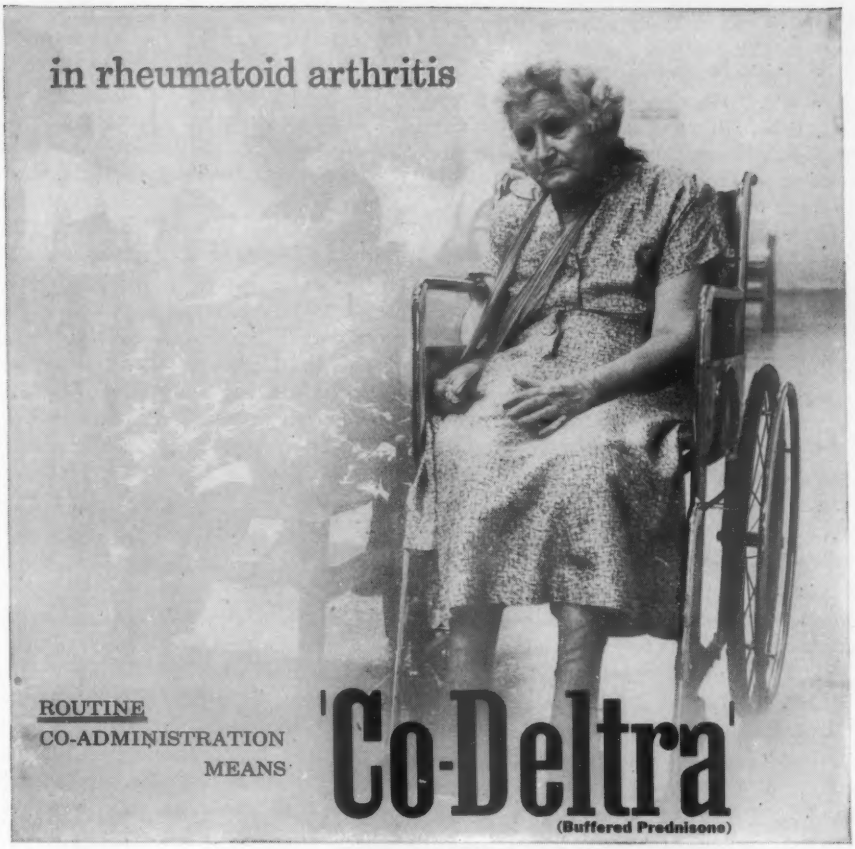
**Retrolental Fibroplasia,** a hopeless condition in early infancy, has been more than adequately reviewed in the literature of the last five years. I will mention only that prematures should be carefully controlled as to the amount of oxygen they receive. Most investigators now feel that the oxygen concentration should not exceed 40 per cent—that oxygen should be given for the shortest period possible, and that it is wise to use a gradual oxygen weaning process.

**Hemangioma** on the lids or periorbital area is a common congenital defect. Fortunately, a large percentage of these lesions will disappear without treatment. For those that do not, some type of surgical approach, such as dry ice, sclerosing solutions, or best of all, surgical removal, gives good results. Radiation is probably too hazardous to consider.

One problem which seems to plague general practitioners is that of tearing in the first year. Many of these will clear without specific treatment, other than local antibiotic therapy and massage over the lacrimal sac. Those who do not respond within a month should be seen by an ophthalmologist and have the tear duct opened by a minor surgical procedure.

**Squint or Cross-Eye** constitutes another major problem to the general practitioner, who can best serve here by advising the parents that such a condition does or does not exist, and that further medical help is needed. Two outmoded concepts should be abandoned—first, that children will "outgrow" squint; and second, that nothing should be done until the child is 5 or 6 years of age. Each year squint surgery is being done more regularly in the 1 to 3 year age group. The general practitioner should have at his command a very simple test to determine if a child's eyes are straight, the corneal reflex test: Briefly, a flashlight is held about one-half meter before the child pointing at his eyes, and the relative position of the corneal light reflex is noted on each eye. If the reflex is symmetrical, there is no squint; if the reflex is closer or further in relation to the limbus as compared with the other, the eyes are not straight. The role of the general practitioner in squint is to serve as adviser to the

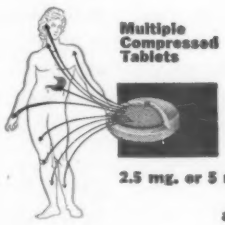
in rheumatoid arthritis



ROUTINE
CO-ADMINISTRATION
MEANS

'Co-Deltra'
(Buffered Prednisone)

'Co-Hydeltra'
(Buffered Prednisolone)



Multiple Compressed Tablets

Clinical evidence[1, 2, 3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

**2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.**

SHARP & DOHME
Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

*References:* 1. Boland, E. W., *J.A.M.A.* **160**:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* **158**:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* **158**:459, June 11, 1955.

'CO-DELTRA' *and* 'CO-HYDELTRA' *are the trademarks of* MERCK & CO., INC.

ALL THE BENEFITS OF THE "PREDNI-STEROIDS" PLUS POSITIVE ANTACID ACTION TO MINIMIZE GASTRIC DISTRESS

family as to when and if the child should be referred. Therefore, he should know the rudiments of squint.

**Trauma** is an important adnexa of "growing up." Ocular trauma unfortunately is all too common, with air-guns, bows and arrows, swords, flippers, and other weapons of childhood. Here there is no simple rule to guide a general practitioner as to what he should or should not handle—but, in general, he should avoid cases that have a marked visual loss in the affected eye. The vision can be tested easily and should be done in each eye by *all* doctors, especially in any case that has a medico-legal aspect. Cases that have a disruption of the normal relationship of the cornea, anterior chamber, iris and pupil should be avoided. Fortunately, we have been provided with two eyes for comparison. On the other hand, a subconjunctival hemorrhage, dreadful as it may appear, is usually harmless, and can be handled most competently by the family doctor.

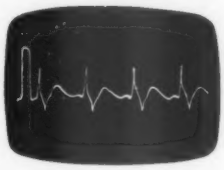
**Allergic Disorders** of the eye are common in children. The usual bacterial inflammations, granulomatous diseases, such as tuberculosis lues, and fungus infections, and to a lesser degree, vascular and metabolic disorders are also common in the younger age group.

**"Red Eye,"** a broad subject, has been discussed in lectures and books almost to a point of severe boredom. But at the risk of being repetitious, I feel that it is necessary to mention the chief conditions causing this, and the differential points in their diagnosis, as it is likely that the patient will first bring his "red eye" to his family doctor. First, I would like to state that local atropine should never be used by a general practitioner. Medical students somehow seem to learn that the only drug to use in the eye is atropine. If you feel the eye is serious enough to need atropine, get rid of it! The four most common causes of "Red Eye" are *Conjunctivitis, Allergy, Iritis* and *Glaucoma.* It is usually these conditions in which the general practitioner errs on the side of undertreatment, claiming he knows nothing about the eye, or on the side of overtreatment, giving them all an antibiotic, argyrol or oxide of mercury, or even atropine, without discrimination. In this way, he does a disservice to the patient, as many of the people he can treat effectively without the additional expense of referral to a specialist. On the other hand, an eye can be lost through improper treatment. In the first instance, a family doctor can treat very well conjunctivitis and allergic disorders. The last two, *Iritis* and *Glaucoma,* should best be referred at once. His real problem resolves to separating the etiology of the "Red Eye." To help do this, I would like to give you what I call my triad of symptoms. This is not as good or complete as the table you all dimly remember in May's book, but it has the advantage that it can be remembered without reference to a book. The three components consist of *vision, pain,* and *congestion.*

In the first two conditions, *Conjunctivitis* and *Allergic Disorders*: the vision is normal, there is no pain, but rather only a mild foreign body type sensation, and the cornea, anterior chamber, iris and pupil are intact. The congestion is *brick red* in color, and is less intense at the limbus than it is farther away. In the latter two conditions, *Iritis* and *Glaucoma*: the vision is usually reduced, and the congestion is more of a *purplish red color* and more intense near the limbus. The cornea may be hazy, the iris muddy, and the pupil not equal to its fellow. Therefore, it is relatively simple to decide which cases to treat and which cases to refer. If the vision is normal, no actual pain is present, and the anterior segment of the globe appears normal, except for conjunctival congestion and discharge, then you may treat the eye with reasonable safety. If the vision is reduced, pain is present, and the normal anatomy of the visible portion of the eye is disturbed, it is best to refer the patient both for his good and yours.

**Foreign Bodies** are encountered more frequently in the 20 to 40 year age group, which is more active in industry. Some of you in this State will have to take care of a considerable number of these cases because of the geographical problem. I would like to mention a few points regarding the actual

Lasker Award statuette



## *an acknowledgment*

We are proud that our television series on the NBC network, "The March of Medicine", has been selected to receive the first Albert Lasker Award in the field of television and radio.

But we feel that those really being honored are you—the physicians and research scientists of America.

Your sense of responsibility to the public—and that of your hospitals, laboratories, and staffs—has made it possible for "The March of Medicine" to report the story of medical progress.

The Lasker Awards heretofore have been bestowed on many of the nation's outstanding medical scientists and journalists. As a member of the pharmaceutical industry, we are particularly grateful for the honor represented by this award.

We are also grateful for the support we have continually received from the American Medical Association, which has cooperated in this series from the very beginning.

Francis Boyer

Francis Boyer
President
Smith, Kline & French Laboratories

technic of this procedure: First, take the vision of each eye, and then instill a local anesthetic such as holocaine 1 per cent, or better, pontocaine ½ per cent. Then evert the upper lid of the affected eye to check for the presence of a foreign body, and if present, remove with a moistened cotton applicator. The cornea should then be inspected for an embedded foreign body and, if found, this should be removed with a suitable steel spud. I prefer one with a fairly sharp triangular tip on one end, and a small dental burr on the other. This latter is excellent for curetting iron-oxide pigment. The pupil should be dilated with homatropine, an antibiotic instilled, and then a mild pressure patch applied. The patient should be seen again in twenty-four hours. His eye should be well or nearly well at that time. If it is not, it is wise to refer the patient for more specialized care. Naturally, a very careful history should be taken of all accident cases, and this will often suggest the possibility of an intra-ocular foreign body. Careful observation of the lids, cornea and conjunctiva should always be made with special attention paid to evidences of a small laceration or perforation of the globe, with particular attention to any disturbance of the normal anatomy of the anterior segment. If there is any doubt whatever, always refer the patient for an x-ray.

**Alkali and Acid Burns** to the eye are frequently found in this age group. These result from plaster, cement, sodium hydroxide, sometimes used as an industrial cleaner, and various acids. When these patients are first seen, they should be given copious flushes of water, and then referred immediately to an ophthalmologist. These are often disastrous eyes to treat, whether in the hands of a general practitioner or an ophthalmologist.

We arrive now at the older age group in which ocular defects again become more common, as in childhood. Here the congenital disorders are less, and are replaced by the degenerative diseases of old age. A good deal of general medicine and ocular pathology now join hand in hand to threaten the patient with the ominous forebodings of old age. Most older people accept pain and locomotion defects with relative stoicism, but the loss of a special sense often proves to be a serious psychological, economic, and social handicap, which may overwhelm them. You have only to contemplate your life without vision or hearing to realize the remarkable functions these senses serve. In the older age group, the eye is unfortunately subject to many disorders, and here the family doctor can, if he wishes, deliver real comfort and aid to a bewildered and frightened patient. The fear of blindness is strong in most people for a variety of reasons, and the family doctor is in a position to relieve this fear with a minimum of delay and expense.

**Cataract** to most patients means blindness, but it should not, since loss of vision due to this, can be most easily relieved. The general practitioner should remember that cataract extraction is now done when the visual loss is such that it interferes with that particular patient's occupation or visual need. Much suffering can come to the patient if he is advised that cataracts have to "ripen" before they can be removed. This type of advice has been out of date for the last twenty years. Also, it might be of interest to know that in recent years, ophthalmologists are removing unilateral cataracts much more frequently than they previously did. As can be readily seen, much harm can be done to a patient, especially economically, by unwise advice. Remember the patient looks to you for *expert* advice in all medical matters.

**Chronic Simple Glaucoma** is one of the most serious ocular problems of the elderly group. Unfortunately, there is no simple diagnostic procedure to determine its presence. The symptoms are insidious, and the findings are minimal. Tonometer measurements on all general patients over 40 years of age is as remote as rountine pelvic and rectal examinations were thirty years ago. The best I can tell you is to have a high "glaucoma suspicion" in all patients over 40 who are complaining of headaches, blurred vision, seeing halos or rings around lights, difficulty in reading, poor night vision, and watery or red eyes. These patients ordinarily have a refraction problem that needs

attention and a referral will be welcomed by them. As you may notice this is my first reference to refraction. I have purposely avoided the subject in an effort to impress upon you that ophthalmology is a medical specialty with refraction a side-issue. Your ophthalmologist is a colleague to help you with medical problems first, and refractions secondarily.

**Uveitis** is a common disorder of older people. These are often difficult to treat and the prognosis may be poor. There is still fair evidence that these cases may be caused by foci of infection in the body, and often require the help of most of the services in hospital to track down the etiological factors.

**Retinal Detachment** is a serious ocular disease, more common in those of the older age group. It requires surgical treatment, and delay in treatment is often disastrous to the eye. A patient who seeks advice with symptoms of flashes of light, a cloud in a portion of his visual field, and a central visual loss, deserves immediate consultation. In a fairly large group of cases of retinal detachments that have come under my observation, I have found this disease to be bilateral in 23 per cent of all cases. For this reason, in cases of detachment in only one eye, I feel that it is wise to advise the patient, regardless of his age, to have detachment surgery, because without surgery, this affected eye is doomed to blindness. If the patient at some later date should develop a retinal detachment in his second eye, and the results following surgery, which then *must* be performed, are bad; any results which might have been obtained with surgery on the first eye would then be invaluable and prevent total blindness to the patient.

**Diabetes and Vascular Lesions of the Brain** can often cause damage to the nuclei of the extra-ocular muscles with resultant sudden diplopia and squint. The general practitioner should be aware of these complications so that he is not taken off guard. *Diabetes* is responsible for one of the most hopeless and heartbreaking causes of blindness that we have today, *Diabetic Retinopathy*. Here the ophthalmologist can help a great deal in softening the blow and preparing the patient for ultimate blindness. Treatment at present is of no avail.

**Hypertensive Retinopathy** from essential hypertension, renal disease, and pregnancy are often a problem to the general practitioner from the visual standpoint. Here the ophthalmologist can serve a real function in that he can give periodic reports of the fundus findings and help to guide your therapeutic regime.

Occasionally in older patients with vascular disease, you will have one come to you with a history of sudden loss of vision in one eye. The lesion is most often in the posterior segment of the eye and will usually prove to be an occlusion of the central vein or artery. Sometimes it may be due to a large vitreous hemorrhage. It is wise to remember that not all vitreous hemorrhages come from hypertensive or arteriosclerotic vessels. Many times they come from diabetic retinopathy. Also some are associated with melanomas of the choroid and retinal detachments.

**Senile Degeneration of the Macula** is another degenerative lesion of the eye in which the general practitioner can play an important part in encouragement to the patient. In this disease the central vision is reduced to about 20/200, or 10 per cent of normal, but the peripheral field of vision remains normal. These people are usually afraid they are going blind, and they are relieved and grateful when they are told that they will no longer be able to read, but that they will *never* go blind. It is a great help to the ophthalmologist to have the general practitioner understand this, and encourage the patient in this regard.

**Corneal Transplant** due to development of the past few years, offers some hope of vision to the occasional patient seen in your practice. This type of surgery however, is applicable only to those cases that have a scarred cornea, and a relatively normal eye back of the cornea. For this reason, one should not encourage blind patients too much regarding the results from a corneal transplant.

Perhaps we should have an anticlimax here and discuss minor ocular surgery which is within the province of the general practitioner to perform. Chalazion of the lid is a fairly common disorder which can be handled very well by the family doctor. One word of advice only—be careful if the chalazion is near the lower punctum. You may destroy it and cause a permanent tearing, a symptom which is very unpleasant, to say the least. I am told by my associate, Dr. Cyril M. Luce, that pterygium is a fairly common lesion on the great Western Desert. I would not advise that this condition be operated by the general practitioner unless he has had some special training in the procedure. However, its position and growth over the cornea should be noted and the patient referred for surgery before the central portion of the cornea becomes involved.

**Diseases of the Central Nervous System** may affect the eye or its adnexa. The family doctor is often the first point of contact for the patient, and he can often serve a real life-saving function if the lesion happens to be an expanding intracranial neoplasm. Here, of course, papilledema is the ocular finding of noteworthy importance. The general practitioner should be sufficiently familiar with the use of an ophthalmoscope so that he can recognize the normal disc from the abnormal. He may not always be able to state that papilledema is present, but at least he should be able to state that the optic disc is, or is not, normal. In this manner he will be alerted to secure more expert opinion.

I would like to endorse and join the crusade of our capable and sincere President of the American Medical Association, Dr. Elmer Hess. He has stated, "Any doctor who goes into the room of a seriously sick patient with only scientific medical knowledge, is not fully prepared, and cannot adequately administer to that patient's needs." I am in full accord with Dr. Hess, and I feel that any doctor to take his place in medicine completely and successfully, must have a sincere belief and confidence in a "Supreme Being" far greater than himself. He must be sympathetic and understanding, and know how to "reach people." Indeed, we as physicians, should remember that we are not just diagnosing and treating a disease; but rather, we are dealing with disturbed minds and souls that are asking for help.

In closing, my purpose here has been to try to bring general medicine and ophthalmology into a closer relationship. You do not have to be an ophthalmologist to diagnose and treat many ocular conditions. Any doctor can do this if he has a mind that functions while observing. The eye is in such an exposed position and is so uniquely suited for observation by the naked eye, that a great many fascinating pathological lesions are waiting and available for the man who will turn his flashlight to the eye and take a *good look*.

---

**DIVIDEND OF EXTRA YEARS OF LIFE**

Death is taking a partial holiday in the United States.

Death was a grimly busy agent back in 1900.

If the same death rates prevailed today, there would be:

Five times as many little caskets bearing infants under 1 year old; twelve times as many for babies 1 to 5.

Four times more funerals each year for adults 25 to 34; three times as many for men and women 35 to 44.

That is one way of expressing the huge dividend of extra years of life won since this century began. The figures come from a survey by the Health Information Foundation.

The death rate, from all causes, per 100,000 people has been chopped nearly in half, the average for all age groups. The greatest area for death's holiday is among babies, but there still are dramatic extensions of life for age groups over 55.

Mortality has been cut 40 per cent among men and women 45 to 54, and 30 per cent among those 55 to 64. It's down 20 per cent for people 85 and older.

Despite these gains, Americans' record of preserving health and life is still "not as good as it might be," declares George Bugbee, president of the Health Information Foundation. The foundation is a fact-finding educational organization sponsored by 200 companies in the drug, pharmaceutical, chemical and allied industries.—B. C. Enquirer and News, Feb. 19, 1956.

plateau therapy*...

for hay fever and other allergies


# CHLOR-TRIMETON
# REPETABS, 8 and 12 mg.

*Because they quickly attain and maintain a prolonged, therapeutic plateau, CHLOR-TRIMETON REPETABS avoid the wave-like levels which may be produced by multiple-release granules or t.i.d. medication ...affording optimal patient comfort.

CHLOR-TRIMETON® Maleate, brand of chlorprophenpyridamine maleate.
REPETABS,® Repeat Action Tablets.

CT-J-766

# Hypogammaglobulinemia (Acquired Agammaglobulinemia)*

H. C. Rosenstiel, M.D.
ALBUQUERQUE, NEW MEXICO

In 1952 and 1953 Bruton, et al., reported three cases in male children of a clinical entity characterized by multiple recurrent severe bacterial infections associated with almost complete absence of serum gamma globulin but with normal total serum protein concentrations[1,2,3]. Sixteen cases identical to Bruton's have been identified by Janeway and his associates[4]. These cases, also, were all in male children. The term congential agamaglobulinemia has been applied to this group. Characteristically these children have a complete absence of serum gamma globulin, even with the use of the most sensitive immunochemical method of determination.

Several similar cases in adults, but with small amounts of gamma globulin demonstrable by the immunochemical method, have also been reported[4,5,6,7]. Either sex may be affected. These cases have been associated with bronchiectasis and an inability to throw off respiratory infections. The term hypogammaglobulinemia has been applied to this group. Characteristically, the blood sera of these individuals reveal absence of gamma globulin by electrophoresis. (The electrophorectic determination method is capable of detecting amounts of gamma globulin greater than 100 mg. per cent.) The sensitive immunochemical method of determination usually reveals amounts ranging from 20 to 50 mg. per cent in these patients.

Hypogammaglobulinemia should be suspected in any adult who has persistent intractable bronchiectasis with recurrent respiratory infections. The electrophoretic determination of the serum proteins is not universally available; therefore, a determination of the isoagglutinins should be used as a screening test. In this entity the isoagglutinin titer is always low or absent. Consequently, any patient with bronchiectasis who has a low or absent isoagglutinin titer should have an electrophoretic determination of the serum proteins.

The patients with hypogammaglobulinemia presumably have an acquired deficiency of lymphoid tissue similar to the lymphoid deficiency which has been noted in autopsied cases of congenital agammaglobulinemia[8]. There is experimental evidence that the primary difficulty in both groups is an inability to manufacture gamma globulin. Passively transferred gamma globulin disappears slowly over a six or seven week period or even longer. Therefore, prophylactic therapy is effective.

For prophylactic therapy immune human serum globulin is administered subcutaneously at monthly intervals at the rate of 0.6 c.c. per kilogram of body weight, which contains a dose of 0.1 gm. gamma globulin per kilogram of body weight[4]. This material is the preparation which is released by the American Red Cross through the Gamma Globulin Distribution Officer of the Department of Health, Education, and Welfare to the Departments of Health in the various states for the modification of measles, poliomyelitis, and hepatitis. It is now obtainable also from commercial sources. Recently the State Health Departments have been authorized to release this material for the treatment of hypogammaglobulinemia or agammaglobulinemia.

## REPORT OF CASE

A 38-year-old white male veteran of World War II was admitted to the Albuquerque, New Mexico, Veterans Administration Hospital on December 17, 1953. His complaints at that time were of chills, fever, cough, and right chest pain

*From the Medical Service, U. S. Veterans Administration Hospital, Albuquerque, New Mexico.

of two days' duration. There had been no hemoptysis. He had received injections of procaine penicillin G on the day of admission, and on the previous day from his private physician.

The patient's past history revealed that since November 29, 1944, he had had many respiratory infections requiring antibiotic therapy, and with many of these illnesses hospitalization in either army, private, or veterans administration hospitals had been necessary. A review of his past medical record revealed twenty attacks of pneumonia, one attack of erysipelas, innumerable colds and sore throats, and many attacks of sinusitis. He had taken prophylactic therapy with sulfonamides until he had developed a sensitivity to them. Also at one time or another he had received prophylactic Aureomycin, Terramycin, penicillin, and antihistamines. Just prior to this admission he had been receiving weekly injections of increasing amounts of a stock respiratory vaccine (Serobacterin of Sharp and Dohme No. 4750). The experience with prophylactic antibiotics had always been that the patient could develop another attack of pneumonia while on a prophylactic dose of an antibiotic, but that larger doses of the same antibiotic would control that attack of pneumonia.

The patient had been hospitalized at this hospital on eight occasions since 1950. In April, 1950, he had pneumonia of the right middle lobe due to a pneumococcus which was treated with penicillin and Aureomycin. At that time a bronchoscopic examination revealed normal findings, and complete bronchograms revealed no evidence of bronchiectasis. In March, 1952, another bronchoscopic examination was performed with normal results. In November, 1952, another bronchoscopic examination and a gastroscopic examination revealed normal findings. On this admission he had an attack of right middle lobe pneumonia and a separate attack of left upper lobe pneumonia. In April, 1953, he had erysipelas of the right neck. In May, 1953, he had left lower lobe pneumonia, and in October, 1953, he had pneumonia of the left lower lobe.

Physical examination on this admission revealed a well-developed, thin, pale, white male who was in moderate distress due to the right lower anterior and lateral thoracic pain. There was no cyanosis or dyspnea. His temperature was 99.4°F. orally, his pulse was 110 beats per minute, and his blood pressure was 110/72. The head and neck were normal save for slight hyperemia of the pharyngeal mucosa. There was splinting of the right chest. Percussion of the lungs was normal, although the breath sounds were decreased over the right lower lung field. There were some crepitant rales over the right lower lobe area. The heart, abdomen, genitalia, rectum, prostate, skin, and lympatics were all normal, as was the neurologic examination.

An x-ray of the chest revealed a pneumonic infiltration of the right lower lobe. The Kahn test and the VDRL slide test were negative. Urinalysis revealed sp. gr. 1.020, with negative albumin and sugar, and microscopic examination revealed 1-15 W.B.C. per high power field. The hemoglobin measured 16 grams per cent, and the white blood count was 5100 cu. mm. with 59 per cent neutrophils, 35 per cent lymphocytes, 4 per cent monocytes and 2 per cent eosinophils. The hematrocrit was 45 per cent R.B.C. and the erythrocyte sedimentation rate was 31 mm. per hour (Wintrobe).

He was treated with aqueous penicillin 300,000 U. intramuscularly every six hours from the 17th to the 28th of December. His temperature became normal within twenty-four hours, and his symptoms had all disappeared in forty-eight hours. An x-ray of the chest on December 23 revealed almost complete clearing of an infiltration. It was decided to discharge him on oral penicillin, 100,000 U. twice daily as prophyactic therapy, and he was advised to continue the weekly injections of stock respiratory vaccine. Before he could be discharged on the 30th of December, he developed a chill with fever, and a chest x-ray revealed a pneumonic infiltration of the right lower lobe lateral to the previous infiltration. His symptoms rapidly subsided on intramuscular aqueous penicillin therapy.

After this attack of pneumonia it was decided to do another complete investigation of this patient to determine whether or not bronchiectasis was present and, if present, whether he should be subjected to surgery. Bronchoscopic examination on January 15, 1954, revealed a normal tracheobronchial tree. Washings were taken to obtain cultures in order that an autogenous vaccine could be prepared. The basal metabolic was —7 per cent, the serum protein bound iodine was 8.8 gamma per cent, and a glucose tolerance test was normal. An esophogram was normal. On January 28, complete bronchograms were obtained. These were interpreted as being consistent with minimal bronchiectasis in the terminal portions of the basilar branch bronchi of both lower lobes and in the right middle lobe. Surgery was not recommended. The day following the bronchograms the patient developed nausea, vomiting, and a chill with subsequent temperature elevation to 102° F. orally. A chest x-ray revealed areas of pneumonic infiltration in the posterior basilar segment of the right upper lobe, and in the left lower lobe. At this time he had been on oral penicillin prophylaxis 200,000 U. four times daily. Aqueous penicillin intramuscularly in a much larger dose was given and the temperature returned to normal in twenty-four hours and all symptoms subsided rapidly. On February 10, the patient again had a chill with fever of 102° F. orally. A chest x-ray revealed recurrence of a pneumonic infiltration in the posterior basilar segment of the right upper lobe. This attack again responded quickly to an

increase of the dose of regular penicillin intramuscularly. On February 16, the patient developed an enlarged tender node just below the right mandibular angle which subsided within a few days. No cause for this was found. The white blood cell count at that time was 14,150 per cu. mm. with 6 per cent immature neutrophils, 81 per cent mature neutrophils, 8 per cent lymphocytes, 3 per cent monocytes, and 2 per cent eosinophils. Since admission the weekly injections of stock serobacterin had been continued. Inasmuch as the washings obtained at bronchoscopy did not produce an organism suitable for production of a vaccine, the patient was removed from prophylactic penicillin therapy in order that a satisfactory sputum culture might be obtained with the next respiratory infection. On March 27, the patient developed productive cough, fever, and sore throat with an enlarged tender lymph node below the left mandibular angle. A chest x-ray revealed no evidence of pneumonia. Sputum cultures were obtained, however, and revealed Neisseria, B. Hemolytic Streptococcus, Micrococcus, Gamma Streptococcus, and Pseudomonas, and an autogenous respiratory vaccine was prepared. Sputum cultures on February 16 and 17 had revealed a pseudomonas from which a vaccine was prepared. Both of these vaccines were begun in increasing amounts subcutaneously at weekly intervals during the latter part of April, the stock respiratory serobacterin was continued, and also Piromen (Baxter) in doses of 4 gamma intravenously twice weekly was begun. This was continued until the latter part of May. The vaccines were continued until mid-July. Additional laboratory studies revealed negative heterophile antibody determination, a normal anti-streptolysin titer, a negative cold agglutinin test, normal liver function tests, normal serum electrolytes, a negative isoagglutinin test, negative twenty-four hour urine specimens for prophyrins and Bence-Jones protein, normal stools and sterile blood cultures on several occasions. The patient had another x-ray-proved attack of pneumonia of the right upper lobe and right middle lobe on April 16. The white blood cell count with this attack was 16,400 per cu. mm. with 9 per cent immature neutrophils, 83 per cent nature neutrophils, 6 per cent lymphocytes, and 3 per cent monocytes. At that time he was treated with large doses of intramuscular aqueous penicillin, and streptomycin 1 gm. intramuscularly three times daily for one week. He received one transfusion of 500 c.c. whole blood. In May, he developed an exacerbation of chronic sinusitis with x-ray evidence of dense clouding in the right maxillary sinus. This sinus required lavage on several occasions for the next two months. A hemogram on June 4 revealed hemoglobin 14.6 gm. per cent, red blood cell count 4,560,000 per cu. mm., white blood cell count 11,700 per cu. mm., immature neutrophils 1 per cent, mature neutrophils 71 per cent, lymphocytes 16 per cent, monocytes 6 per cent, eosinophils 5 per cent, basophils 1 per cent, erythrocyte sedimentation rate 15 mm. per hour (Wintrobe) and hematocrit 43 per cent R.B.C. During the second week in July, he developed right kidney colic type pain and he was thought to be passing a calculus. The urine contained albumin 2 plus, many pus cells and some red blood cells. Urine culture revealed an aerobacter aerogenes and intravenous and retrograde urograms revealed evidence of pyelonephritis, right. These symptoms subsided on Achromycin 250 mg. four times daily and subsequently repeated urinalyses revealed no abnormalities.

On March 24, an electrophoretic study* of the serum proteins revealed albumin 3.79 gm. per cent, alpha 1 globulin 0.29 gm. per cent, alpha 2 globulin .69 gm. per cent, beta globulin 0.52 gm. per cent, and gamma globulin 0.16 gm. per cent. Normal values of these various blood protein fractions are: albumin 4.23 gm. per cent $\pm$ 0.29 gm. per cent, alpha 1 globulin 0.28 gm. per cent $\pm$ 0.06 gm. per cent, alpha 2 globulin 0.68 gm. per cent $\pm$ 0.10 gm. per cent, beta globulin 0.89 gm. per cent $\pm$ 0.08 gm. per cent, and gamma globulin 0.93 gm. per cent $\pm$ 0.13 gm. per cent. On May 17, another electrophoretic serum protein study revealed 0.00 gm. per cent gamma globulin and a repeat on June 6, revealed 0.00 gm. per cent.

Permission to use immune human serum globulin was finally obtained from the New Mexico State Department of Health, and the first injection was given on June 29. The dose given was only 20 c.c. because the publication containing Janeway's doseage recommendations had not yet been received[1]. Subsequently, the patient received 38 to 40 c.c. doses at four week intervals on July 27, August 24, September 21, October 19, and November 16. Serum protein determinations were made at weekly intervals from July 6 to November 3. These are shown graphically in Fig. 1. Note that the gamma globulin value remained between 0.25 gm. per cent and 0.48 gm. per cent from August 4 to November 3.

Since mid-July the patient has had no illnesses except for one or two colds which have responded to the usual symptomatic measures.

---

*The electrophoretic protein determinations were performed by R. D. Strickland, Ph.D., Biochemist at this institution. Whatman No. 1 filter paper strips were used in a Veronal buffer of pH 8.6, ionic strength 0.1. The voltage used was 150. The electrophoresis was carried out over a 16-hour period. Following electrophoresis the strips were stained in a solution of Ponceau No. 2 R in a solvent consisting of 4.5 parts methanol, 4.5 parts water, and 1 part Glacial Acetic Acid. The excessive dye was removed by repeated washing in the solvent. Then the dye was luted with 1/10th normal sodium hydroxide solution, and the determinations were made in a Coleman Junior Spectrophotometer.

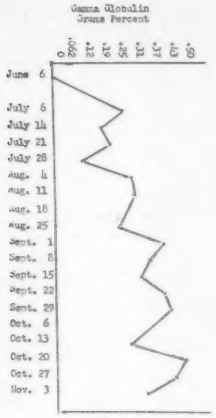



Fig. 1

**Discussion**

This patient developed no increase in the gamma globulin from April to July, during which time he received weekly injections of increasing amounts of the stock serobacterin and of two separate autogenous vaccines. After prophylactic therapy was begun, significant amounts of gamma globulin were found in the serum when estimations at weekly intervals were performed. It is not known as yet if recurrent bouts of pneumonia will be prevented by maintenance of the gamma globulin in the range from 0.25 to 0.50 gm. per cent. There has been no attack of pneumonia since April, 1954. However, this man has had other periods of this length of time when there was freedom from such attacks. The patient is now working full time at his usual occupation as autoparts man, whereas for at least two years prior to December, 1953, he had been unable to do so.

**REFERENCES**

[1]Bruton, Col. O. C.: Agammaglobulinemia. Pediatrics, Vol. 9, January-June, 1952. p. 722.

[2]Bruton, Col. O. C.; Apt, L.; Gitlin, D.; and Janeway, C. A.: Absence of Serum Gamma Globulins. Amer. J. Dis. of Ch., Vol. 84, July-December, 1952. p. 632.

[3]Bruton, Col. O. C.: Agammaglobulinemia. Med. Ann. Dist. Col., Vol. 22 No. 12, December, 1953. p. 648.

[4]Discussion of Therapeutics, Hypogammaglobulinemia in an Adult. Am. Pract. Dig. of Treat., Vol. 5, No. 6, June, 1954. p. 487.

[5]Sanford, J. P.; Favour, C. B.; and Tribeman, M. S.: Absence of Serum Gamma Globulins in an Adult. New Eng. Jour. Med., Vol. 250, No. 24. June 17, 1954. pp. 1027 to 1029.

[6]Grant, G. H., and Wallace, W. D.: Agammaglobulinemia. Lancet, Vol. 267, No. 6840, Oct. 2, 1954. pp. 671-673.

[7]Prosad, A. S., and Koza, D. W.: Agammaglobulinemia. Ann. Int. Med., Vol. 41, No. 3, Sept., 1954. pp. 629 to 638.

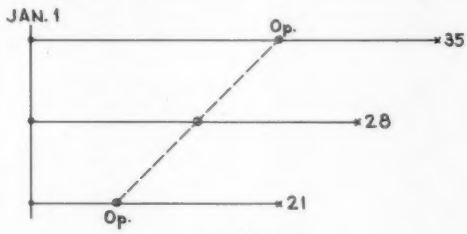
[8]Janeway, C. A.; Apt, L.; and Gitlin, D.: Aggamaglobulinemia. Trans. Assoc. of Amer. Phys., Vol. 16, 1953. pp. 200-202.

[9]Janeway, C. A.: The Clinical Use of Gamma Globulin. The Practitioner, Vol. 161, Oct., 1948. pp. 333-338.

# *Duration of Pregnancy**

Lawrence T. Brown, M.D.
DENVER

DURATION of "normal" pregnancies will vary inversely with the length of menstrual intervals. So many unknown factors influence the duration of "normal" pregnancies that a large number of cases are required to show the trend.



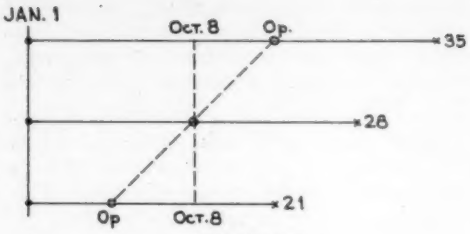

GRAPH 1

Graph 1 may be taken to be a diagram of the first month of pregnancy of three women. Each menstruated on January 1. Mrs. A. has 35 day menstrual intervals; opinion says she ovulates on January 21. Mrs. B. has 28 day menstrual intervals and ovulates on January 14. Mrs. C. has 21 day intervals; opinion says she ovulates on January 7.

In Graph 2, the due dates, October 8, have been superimposed upon Graph 1.

In the diagram, Mrs. B. ovulates, becomes pregnant and delivers on the same spot. Mrs. A., by opinion, ovulates and becomes

*Presented at the annual session of the Colorado State Medical Society in Denver, September 23, 1955.

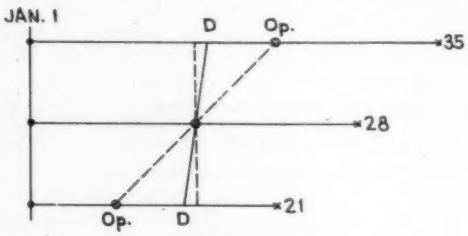


GRAPH 2

pregnant on January 21. Does she, on the diagram, deliver seven days earlier than ovulation, on October 8? Mrs. C., by opinion, ovulates and becomes pregnant on January 7. Does she, on the diagram, deliver seven days later than ovulation, on October 8?

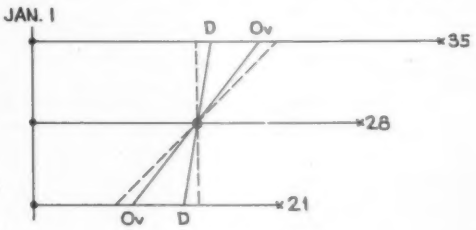
By commonly accepted opinion, women with menstrual intervals longer than average will deliver later than their due date. Does Mrs. A. deliver seven days later than due date, putting her delivery (on the diagram) on her day of ovulation as Mrs. B. does? Does Mrs. C. deliver seven days earlier than due date, putting her delivery (on the diagram) on her day of ovulation as Mrs. B. does?

To answer these questions, the actual days of delivery of women with longer than average menstrual intervals was plotted. That plotting determines a line which crosses the 35 day line two days later than October 8. The actual days of delivery of women with shorter than average menstrual intervals was plotted. That plotting determines a line which crosses the 21 day line two days earlier than October 8. This is shown in Graph 3.



GRAPH 3

Three researchers, Riley, Dontas, Gill, from the University of Michigan,* using women with longer than average menstrual intervals plotted their actual dates of ovulation. This plotting determines a line which crosses the 35 day line 1½ days earlier than opinion. They used women with shorter intervals and plotted the actual days of ovulation. This plotting determines a line which crosses the 21 day line 1½ days later than opinion. These are shown on Graph 4.



GRAPH 4

Mrs. A. ovulates and becomes pregnant on January 19 and delivers on October 10. Mrs. B. ovulates and becomes pregnant on January 14 and delivers on October 8. Mrs. C. ovulates and becomes pregnant on January 8 and delivers on October 6.

**Conclusion**

Women with menstrual intervals seven days *longer* than average will, in spite of delivering two days *past* due date, have a duration of pregnancy 3½ days *shorter* than average.

Women with menstrual intervals seven days *shorter* than average will, in spite of delivering two days *before* due date, have a duration of pregnancy 3½ days *longer* than average.

*Fertility and Sterility 6:86-102, March, 1955.

**EXAMINATION OF THE MOUTH**

**A routine medical examination of the mouth is far too often hasty. The average examination consists of asking the patient to open the mouth and say "ah." About all that is accomplished thus is a cursory glance at the surface of the tongue, occasionally the inside of the cheeks and the palate, and perhaps a slight glimpse of the tonsils. Many tumors are not recognized by such superficial inspection.—Ward and Hendrick.**

# The **NEW** Phenothiazine Derivative

# Sparine

## For the Management of the Acutely Agitated Patient

• ***The acute alcoholic*** • ***The acute psychotic*** • ***The drug addict***

**A promising new agent in chemopsychotherapeutics, SPARINE has demonstrated impressive effectiveness in controlling acute excitation without inducing significant side-reactions.[1,2,3]**

**SPARINE is a new, clinically effective phenothiazine derivative, which may be administered intravenously, intramuscularly, or orally. The route and dosage are determined by the extent of central-nervous-system excitation and by the patient's response.**

**Supplied: Tablets, 25, 50, and 100 mg., bottles of 50 and 500; 200 mg., bottles of 500. Injection, 50 mg. per cc., vials of 2 and 10 cc.**

**1. Seifter, J., et al.: To be published. 2. Fazekas, J.F., et al.: M. Ann. District of Columbia 25:67 (Feb.) 1956. 3. Mitchell, E.H.: J.A.M.A. In press.**

®

**Philadelphia 1, Pa.**

*Trademark

**An Exclusive Development of Wyeth Research**

# The Do-It-Yourself Syndrome — Presidential Address*

Stuart W. Adler, M.D.
ALBUQUERQUE

DURING the past few years a new situation has been created by the Do-It-Yourself craze. It has been estimated that at least 500,000 individuals are injured each year in the various and sundry accidents that occur when inexperience and great ambition meet at the tool bench or on the rooftop. This expanding field of worthy endeavor contributes to medical practice and is a trend of the times which can be classed as economic boom.

The reference in the title of my remarks is not, however, to this phase of Do-It-Yourself activity. Rather, I sound a warning that we as doctors must work together against any threat to the survival of the free enterprise system of medical practice. If the majority of the physicians of this country see fit to defend themselves only as individuals, the resultant action would be ineffectual. If there is failure to join hands with others in dealing with many phases of our professional relations, outside actual practice, we doctors are going to learn too late that ours is a lost cause. We will have to develop the Do-It-Together approach.

A new year is starting for the New Mexico Medical Society and there is work to be done. My predecessor has reported on the state of your Society and indicated to us his hopes for further progress. He has the right to expect continuing effort on the part of all of us in extending the worthy endeavors of the past year as well as completing any unfinished business.

My concern is about the new year which is just beginning. After observing the activities of our State Society for several years past, I am firmly convinced that the road ahead becomes harder each year. In no one year can we ever hope to attain a completely satisfactory relationship with all the government programs, with the activities of various professional and lay groups, and with the problems of our patients and their friends. However, carefully planned action by the Society representing a united effort of its membership, can bring us step by step to a point where—as physicians—our counsel will be sought, our opinions respected, and our suggestions acted upon by spokesmen for public groups and those persons responsible for various health programs.

**Study Congressional Bills**

Our position in the matter of national medical care programs, including pending legislation, calls for prompt and vigorous expression and action. It should be the concern of all physicians that all individuals who need medical care or welfare benefits receive the same in adequate measure. In addition to the care given by us as private physicians, there are many phases of public health and welfare which of necessity dovetail with our personal efforts. There are also some phases of government-sponsored health activities which supercede medical care rendered privately.

Whatever our individual reactions may be to certain public health programs, as a Society we cannot ignore them nor reject them. Rather, we must use our influence to make such programs satisfactory. It should be the concern of the State Medical Societies to insure proper standards for, and proper limitation of, all government-sponsored medical service programs and welfare activities.

You are fully aware that various features of bills now pending in Congress are unfavorable to the practice of medicine as a

*Read May 2, 1956, before the 74th Annual Session of the New Mexico Medical Society, Roswell.

private venture. It is your duty to familiarize yourself with these bills. You cannot help influence their passage or defeat unless you recognize their favorable or objectionable features. You can further your Society's expressed attitude toward these pending enactments by writing your Congressman, the chairmen of committees before which hearings are being held, and by getting friends, influential citizens, and when possible your patients to do the same.

Within our own state we should be able to observe public health and welfare programs proceeding smoothly to provide the best possible services for those entitled to any form of assistance. We should also be aware of obvious infringement on the private practice of medicine. To accomplish any needed adjustments in these situations, we, as a professional group, must be able to command the respect of our State Legislature in health matters. We can only do that by representing a united medical profession when advice is sought, or when we as a Society wish to bring various matters to the attention of the Legislature. We can hardly expect constructive laws to be enacted when two lobbies of Doctors of Medicine appear on opposite sides of a controversial subject. It would be better that we had nothing to do with any phase of legislation if we are unable to present the thinking majority of the Society.

This does not mean that rugged individuals among us, with intense interest in a given cause, cannot be heard. But all debate should be confined to County and State Medical Society meetings so that, before the public and in the press, there will be expressed only the opinions and will of the majority of doctors in those societies. It is my sincere hope that we can come to a working agreement within the State Society in regard to the legislation we may seek or attempt to defeat in 1957. It should be arranged that: first, no opposition from members of the Society will be voiced publicly counter to the expressed wish of the majority; second, that the Legislative Committee of the Society have adequate support in the preparation and presentation of bills pertaining to medical matters.

**Public Relations Can Be Helped**

Our relations with the public in general need to be greatly improved, even after years of attempting to do just that. In united action as a Society, there must be better and fuller interpretation to the public of our thinking in the whole field of healthful living. We need to conduct an active campaign to inform the public why we oppose socialized medicine—why fees are what they are—the relationship between attending physician, the consultants, and the patient—what constitutes ethical conduct, and other pertinent subjects. When we have clearly defined our thinking within the Society in regard to the extent and manner of cooperating with the State Public Health Department and its program, we must in turn spell this out very simply to the public.

We should maintain satisfactory relations with the press, and from personal experience, I know this can be realized with a little careful planning and a somewhat modernized approach. We will have to be realistic about our thinking in regard to our relationship to others in our community who practice the healing arts with full legal authority in ways other than our own. A rapidly changing attitude, the country over, makes it difficult to know just what is best in these relationships and how to deal with conflicts that arise.

Within our own house, so to speak, there are other problems dealing with doctor-patient relationships. It is not expected that any of us can judge whether any other physician is always doing the best of which he is capable. Rather, as a group, we should set standards of conduct and professional skill high enough, so that, when accepted and adhered to, there will be no basis for criticism of doctors by patients or the general public.

It is apparent that a considerable list of grievances can be laid at the door of most of us which at times provoke unfortunate patient-to-doctor and doctor-to-doctor relations. They are all matters which can be set right with ease if we as individuals will rid ourselves in some degree of that unfortunate trait of selfishness. A little self-restraint can be prescribed for all of us,

and if taken, generally proves to be pretty good medicine. Let us remember that we have the machinery set up to hear complaints against doctors regardless of the source. With some slight changes in manner of procedure, it is hoped that this year complaints to the Grievance Committee will be handled promptly and with legal safeguards to those charged with investigation. Fortunately, complaints are not numerous and a thoughtful doctor can, by discreet handling, avoid formal action in many instances. If we can keep our house in order, we command respect from all those with whom we come in contact.

To serve as your President is a genuine honor and at the same time a tremendous responsibility. Whether you realize it or not, you really select a moderator, one who does not make the rules or necessarily plan the show. In reality, the program of the State Medical Society is your program; put into operation by your governing bodies; and dependent largely on your participation for any degree of success it may enjoy.

**Safety Campaign Needed**

It is probably not out of order to indicate at least two of the things which will be presented to you for your consideration if approved by the Council. First, participation in an accident-prevention and general safety campaign. If each of us conducts our daily practice with these problems in mind, much can be accomplished. There are ways in which the State Society can help as an organization. Secondly, as individuals and as members of the State Society, perhaps we have been overlooking the potential strength of a large group who could be recruited in a greater effort to improve our public relations. I refer to the expanding Woman's Auxiliary to our County and State Societies and to the persons working in our offices who really meet the public. If these groups can be helped to understand more fully how they can help us, we could count on better public understanding of our professional aims—and personal limitations. Other states are doing more with these groups than are we in New Mexico.

There will be routine duties for all of us in the State Society, and it is hoped that more doctors can be drawn into active participation in the Society's program. This means giving time and effort and making the necessary personal sacrifice when called on to help.

May I again express my sincere appreciation for the honor you have conferred on me and give you assurance that I will serve the Society to the best of my ability; try to interpret your wishes; and undertake a program designed to make the New Mexico Medical Society as potent a force as possible on the national as well as the state level. If our program is successful, what we accomplish this year may help make the practice of medicine a little more pleasant and satisfying for you in the community where you live.

It is my sincere wish that, for the good of the medical profession as a whole, we can make use of a proven prophylactic against the Do-It-Yourself Syndrome by making a genuine effort by doctors collectively, as a Society. We simply are not strong enough as individuals.

---

**ANTIHISTAMINICS AND COLDS**

As far as the common cold is concerned, the antihistaminics seem to have overstayed the enthusiastic welcome which they received a few years ago. Basing their judgment on several apparently sound studies, the profession and the public hailed the long-sought cure with much soundings of trumpets—and noses. Unfortunately, later, perhaps more exact studies could not substantiate the early claims, and sniffles and snuffles continued in spite of the generous use of the supposedly curative drugs.

The present situation in which many manufacturers still proclaim the virtues of the antihistaminics in the upper respiratory infections is typical of that in which many drugs have been found in the past. While their introduction may take only a few days or months, their ejection from current therapy may require decades of disappointment.—J. of the So. Carolina Med. Assn.

IMPORTANT RESEARCH CONTRIBUTION

*Searle Introduces:*

# A Practical New Steroid for Protein Anabolism

# Nilevar*

(BRAND OF NORETHANDROLONE)

**PROTEOGENIC EFFECTIVENESS** • The newest Searle Research development, Nilevar, exerts a potent force in protein anabolism. Yet it is without appreciable androgenic effect (approximately one-sixteenth of that exerted by the androgens).

Investigations with Nilevar show that nitrogen, potassium and phosphorus are retained in ratios indicating protein anabolism. Nilevar is thus the first steroid which is primarily anabolic and which provides a practical means of meeting the numerous demands for protein synthesis.

**NILEVAR IS ORALLY EFFECTIVE** • Clinical response to Nilevar is characterized not only by protein anabolism but also by an increase in appetite and an improved sense of well-being.

**SAFETY AND PRECAUTIONS** • Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently.

**DOSAGE** • The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the daily dose is 1 to 1.5 mg. per kilogram of body weight. Individual dosages depend on need and response to therapy. Nilevar is available in 10 mg. tablets. G. D. Searle & Co., Research in the Service of Medicine.

**INDICATIONS:**

**Nilevar is indicated in the vast area of surgical, traumatic and disease states in which protein anabolism is desirable for hastening recovery. The specific indications are:**

1. **Preparation for elective surgery.**
2. **Recovery from surgery.**
3. **Recovery from illness: pneumonia, poliomyelitis and the like.**
4. **Recovery from severe trauma or burns.**
5. **Nutritional care in wasting diseases such as carcinomatosis and tuberculosis.**
6. **Domiciliary care of decubitus ulcers.**
7. **Care of premature infants.**

*Trademark of G. D. Searle & Co.

SEARLE

# ACHROMYCIN*

Tetracycline *Lederle*

*in the treatment of*

## infections in surgery

The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

For example, Albertson and Trout[1] have reported successful results with tetracycline (ACHROMYCIN) in diverticulitis, gangrene of the gall bladder, tubo-ovarian abscess, and retropharyngeal abscess. Prigot and his associates[2] used tetracycline in successfully treating patients with subcutaneous abscesses, cellulitis, carbuncles, infected lacerations, and other conditions.

As a prophylactic and as a therapeutic, ACHROMYCIN has shown its great worth to surgeons, as well as to internists, obstetricians, and physicians in every branch of medicine. This modern antibiotic offers rapid diffusion and penetration, quick development of effective blood levels, prompt control over a wide range of organisms, minimal side effects. There are 21 dosage forms to suit every need, every patient, including

## ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Broad-range antibiotic action to fight infection; important vitamins to help speed normal recovery. In *dry-filled, sealed* capsules for rapid and complete absorption, elimination of aftertaste.


[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

Lederle

LEDERLE LABORATORIES DIVISION
*AMERICAN CYANAMID COMPANY*
PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

PHOTO DATA: AERIAL CAMERA WITH K-2 FILTER AT DUSK, F.11, 4/100 SEC., FAST PAN FILM

ACHROMYCIN ACHROMYCIN

# The Washington Scene

*A monthly news summary from the nation's capital by the Washington Office of the A.M.A.*

As might be expected, a Presidential Commission's report on veterans' pensions that also goes into the subject of non-service connected medical benefits is stirring up another controversy.

The President's Commission on Veterans Pensions, headed by Gen. Omar Bradley, World War II leader and postwar Veterans Administrator, conducted a study covering more than a year in time and a wide range of subjects. It produced a 415-page report and a total of seventy recommendations.

The seven-man commission's report has this basic premise: military service in time of war or peace should be treated as discharging an obligation of citizenship and not of itself as a basis for future government benefits.

The commission made this additional point: ". . . under conditions of modern technology and warfare, the national defense might be served equally well by a civilian in a scientific laboratory or a war plant as by a uniformed serviceman —and in view of total war and atomic weapons, perhaps with greater personal hazard to the civilian. This further suggests that the special needs that veterans have because of military service should not be confused with the needs that all citizens have in common for such things as education, health services and economic security."

With this in mind, the commission proposes the gradual elimination of non-service connected benefits and observes: "Their justification is weak and their basic philosophy is backward looking rather than constructive." Such benefits, it adds, should be limited to a minimum level and retained only as a reserve line for veterans who fail to qualify for basic protection under Old Age and Survivors Insurance (Social Security).

The commission then goes one step further by recommending an end to the present automatic "presumption of service-connection" procedure. Now, presumption of service connection is automatic and mandatory for certain diseases if the condition is diagnosed within a specific period of time following discharge. Instead, the commission would substitute medical determination for chronic and tropical diseases, psychoses, tuberculosis and multiple sclerosis, with each case decided on its own merits.

Other recommendations: (1) increased reliance on the OASI system for certain veterans benefits, (2) prompt counseling of all veterans placed on compensation rolls as to VA and federal-state rehabilitation programs, and (3) requirement of reasonable medical or surgical treatment before payment of compensation.

Representatives of veterans groups called before the House Veterans Affairs Committee to comment on the Bradley study complained that some of its proposals would be "extremely destructive" to certain aspects of veterans compensation.

* * *

**Notes:**

Two committees of Congress, after long studies of problems of narcotics, barbiturate and amphetamine addiction, have come up with recommendations that the U. S. tighten penalties on narcotics peddling and smuggling, outlaw heroin and set up a central unit in the Federal Bureau of Narcotics to keep track of known addicts. The proposals were made by the Senate Judiciary Committee and a House Ways and Means subcommittee.

The House committee also suggested a law for more stringent controls over barbiturates and amphetamines.

The Senate committee rejected the proposal backed by the New York Academy of Medicine for "clinics" where known addicts could go for regular doses of narcotics.

* * *

U. S. Public Health Service is advising private physicians as well as health officers to increase their use of Salk poliomyelitis vaccine. Although supplies now lag behind demand, the expectation is that before the summer is out the situation will be reversed. In line with this recommendation, PHS is urging that physicians use what supplies they have on hand immediately, depending on future production to take care of second and third shots.

* * *

Because the President signed the military career incentive bill promptly, physicians in uniform received their pay raises starting May 1. The minimum boost (after two years' service) is $50 per month, the maximum (after 10 years) $150.

* * *

Private-profit nursing homes, hospitals and some other medical facilities soon will have an opportunity to obtain U. S. loans from the Small Business Administration. The limit is $250,000 per project, the interest rate usually 6 per cent.

* * *

If there was any question about it, the AFL-CIO as a joint organization favors national compulsory health insurance, as each group did before the merger. The AFL-CIO stand was taken officially for the unions by Nelson Cruikshank in testimony before the House Ways and Means Committee on a bill for increased payments for the medical care of public relief recipients.

**save the cigarette for later...** Time was you had to wait for a local anesthetic to take hold —you waited, patient waited, nurse waited. **Now, rapid anesthesia....** Blockain* works so fast that clinicians had to describe it as "immediate" and "almost instantaneous." It's practically an understatement to call its action "rapid." **Longer anesthetic duration....** Besides being able to go to work sooner, you can work at an easier pace. Blockain lasts long enough so you can proceed from incision to closure on one injection. You finish up with a neat suture line undistorted by repeated instillations. The patient leaves uncomplaining and comfortable. ☞ *A busy clinician's experience with Blockain in fourteen cases of Colles' fracture:* A single 2-5 cc. injection of Blockain into the hematoma produced anesthesia in an average of 3 minutes 15 seconds. The average duration of these operations, closed reductions, was 25 minutes. Anesthesia persisted beyond the time required for reduction permitting splints to be applied, postreduction X-rays to be taken and the patients sent home feeling comfortable. **BLOCKAIN,** 30 cc., 0.5% (5 mg/cc.). Your office-ideal local anesthetic. For additional information write GEORGE A. **Breon** & COMPANY, 1450 Broadway, New York 18, N. Y.

*BLOCKAIN® BRAND OF PPOPOXYCAINE HYDROCHLORIDE BREON.

# ORGANIZATION

## *PROGRAM*

**TENTH ANNUAL ROCKY MOUNTAIN**

**CANCER CONFERENCE**

**JULY 11 AND 12 — DENVER**

**Sponsored by Colorado State Medical Society and Colorado Division of the American Cancer Society**

No Registration Fee

**Shirley-Savoy Hotel**

**WEDNESDAY, JULY 11**

**Morning Session**

9:00—Introduction—John S. Bouslog, M.D., Chairman.

9:10—Address of Welcome—V. V. Anderson, M.D., President, Colorado Division, American Cancer Society, and Robert T. Porter, M.D., President, Colorado State Medical Society.

9:30—Symposium—Cancer of the Breast.

Moderator, Mordant E. Peck, M.D.

Panel Members: Grant Sanger, M.D.; Eugene P. Pendergrass, M.D.; Charles Huggins, M.D.; Dwight H. Murray, M.D.; Lauren V. Ackerman, M.D.

12:00—Round Table Luncheon.

Presiding: Frederick H. Brandenburg, M.D.

1:45— **Afternoon Session**

Presiding: Harold T. Low, M.D., Pueblo.

2:00—"Evaluation of Triple Biopsy for Breast Carcinoma"—Grant Sanger, M.D.

2:30—"The Pathological Findings in Leukemia in Children Based on 49 Necropsies"—John R. Schenken, M.D.

3:00—"Early Small Lesions of the Rectum" —George V. Brindley, M.D.

3:30—"Cancer of the Prostate" — Charles Huggins, M.D.

**Evening**

Banquet, Green Gables Country Club

6:30—Social Hour.

7:00—Dinner.

Speaker, Dwight H. Murray, M.D. —"A General Practitioner Looks at Hospital Accreditation."

**THURSDAY, JULY 12**

**Morning Session**

9:30—Symposium—Lymphomas and Leukemias.

Moderator: John H. Amesse, M.D.,

Panel Members: John R. Schenken, M.D.; Eugene P. Pendergrass, M.D.; George V. Brindley, M.D.; Charles L. Dunham, M.D.

12:00—Round Table Luncheon.
Presiding: Charley J. Smyth, M.D.

1:45— **Afternoon Session**

Presiding: John H. Darst, M.D.

2:00—"Cancer of the Thyroid, Its Pathologic Evaluation and Treatment"—Lauren V. Ackerman, M.D.

2:30—"The Impact of Atomic Energy Activities on Medicine and Medical Research"—Charles L. Dunham, M.D.

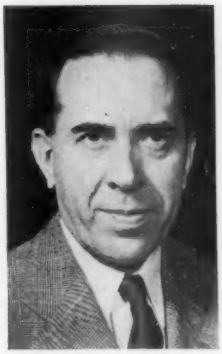
3:30—Adjourn.

# Guest Speakers

**DWIGHT H. MURRAY, M.D.**
**Napa, California**
1956-1957 President
American Medical Assn.

**GRANT SANGER, M.D.**
**New York, N.Y.**
Assistant Professor of Clinical Surgery, Columbia University College of Physicians

**CHARLES HUGGINS, M.D.**
**Chicago, Illinois**
Ben May Laboratory for Cancer Research



**LAUREN V. ACKERMAN, M.D.**
**St. Louis, Missouri**
Department of Surgery
School of Medicine
Washington University

**EUGENE PENDERGRASS, M.D.**
**Philadelphia, Penn.**
Professor of Radiology
School of Medicine
Univ. of Pennsylvania

**CHARLES L. DUNHAM, M.D.**
**Washington, D. C.**
Director, Division of Biology and Medicine
Atomic Energy Commission

**GEORGE V. BRINDLEY, M.D.**
**Temple, Texas**
President American Cancer Society

**JOHN R. SCHENKEN, M.D.**
**Omaha, Nebraska**
Nebraska Methodist Hospital

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness, as well as benefits for hospital expenses for you and all your eligible dependents.


SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$23,800,000 PAID FOR BENEFITS SINCE ORGANIZATION

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA


for
P-R-O-L-O-N-G-E-D
Anticoagulant Therapy

LIPO-HEPIN DARWIN Heparin Sodium U.S.P.

★ Economical... ★ Convenient...
★ Effective... ★ Reliable...

*Easily Administered — A Proven Product*
**Biologically standardized aqueous solution of highest purity**
**Federal contract item #GS-03S-17537**
For subcutaneous, intravenous, or intramuscular use
**Concentrations of: 200 mg., 100 mg., 50 mg. and 10 mg. per cc.**
Consult your pharmacist for details
Literature available: "Heparin in Fat Metabolism," "Heparin Anti-Coagulation"

ADRENAL CORTEX INJECTION

*Available for the first time as a U. S. P. item*

ADRENALEX DARWIN U.S.P.

***Assay:*** Rat-liver glycogen deposition test in accordance with U.S.P. XV monograph.

***Potency:*** Each ml. exhibits a biological activity equivalent to that of 100 mcgms. of U.S.P. reference standard hydrocortisone.

**Adrenalex offers a normal unaltered spectrum of corticords and is recommended for use in all hypoadrenal conditions.**

For intravenous, intramuscular, or subcutaneous use
***Available*** **in 10cc and 30cc Aqueous • 5cc in Oil Oral Capsules**

*Literature and information upon request*

DARWIN
New York Chicago Los Angeles
PACIFIC COAST DIVISION
8240 Santa Monica Blvd., Los Angeles 46, Calif.

## clinically proved in many common infections[1-66]

**Hemolytic streptococcal infections**

Pharyngitis/Tonsillitis/Sinusitis
Otitis media/Mastoiditis
Scarlet fever/Lymphadenitis/Erysipelas

**Staphylococcal infections/Pneumococcal infections/Gonococcal infections/Vincent's infection/Prevention of streptococcal infection in individuals with a history of rheumatic fever/Prevention of secondary infection due to penicillin-susceptible organisms**

## in dosage of just 1 or 2 tablets t.i.d.

## and is far less costly than other penicillin salts

# Pentids

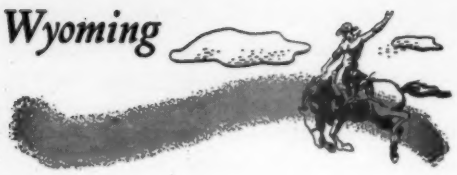
SQUIBB 200,000 UNIT BUFFERED PENICILLIN G POTASSIUM TABLETS

**Recommended dosage:** 1 or 2 tablets t.i.d. without regard to meals. Bottles of 12 and 100.

**References:** 1. Boger, W. P., J. Amer. Ger. Soc. 3:556, Aug. 1955. 2. Lapin, J. H., Ann. Allergy 13:169, March-April 1955. 3. Andelman, M. B. and Fischbein, W. I., Antibiotic Med. 1: 136, March 1955. 4. Statements of American Heart Association, Council on Rheumatic Fever and Congenital Heart Disease, Circulation 11:317, Feb. 1955. 5. Miller, J. M. et al., Antibiotics Annual 1954-55, Medical Encyclopedia Inc., N. Y., p. 105. 6. Seal, J. R. et al., J. Lab. & Clin. Med. 44:831, Dec. 1954. 7. Martin, W. J. et al., Am. Pract. & Dig. Treat. 5:813, Oct. 1954. 8. Henner, R., Eye, Ear, Nose & Throat Monthly 33:530, Sept. 1954. 9. Rodstein, M. and Young, D., Clin. Med. 61:695, Sept. 1954. 10. Bernstein, S. H. et al., A. M. A. Arch. Int. Med. 93:894, June 1954. 11. Craige, E., North Carolina M. J. 14:593, Dec. 1953. 12. Barach, A. L., J. Amer. Ger. Soc. 1:616, Sept. 1953. 13. Barach, A. L., Geriatrics 8:423, Aug. 1953. 14. Boger, W. P., Indus. Med. & Surg. 22:288, July 1953. 15. Young, D. and Rodstein, M., J.A.M.A. 152:987, July 1953. 16. Queries and Minor Notes, J.A.M.A. 152:1083, July 1953. 17. Roberts, E., A. M. A. Amer. J. Dis. Child. 85: 643, June 1953. 18. Spink, W. W., J.A.M.A. 152:585, June 1953. 19. Huang, N. N. and High, R. H., J. Pediat. 42:532, May 1953. 20. Antibiotics: Round Table Discussion, Pediatrics 11:270, March 1953. 21. Feinberg, B., Rhode Island M. J. 36: 138, March 1953. 22. Flippin, H. F., Delaware State M. J. 25: 55, March 1953. 23. Denny, F. W. Jr., Postgrad. Med. 13:153, Feb. 1953. 24. Flood, J. M., A. M. A. Arch. Dermat. & Syph. 67:42, Jan. 1953. 25. Kohn, K. H., Milzer, A. and MacLean, H., J.A.M.A. 151:347, Jan. 1953. 26. Siegal, S. et al., J. Allergy 24:1, Jan. 1953. 27. Statements of American Heart Association, Council on Rheumatic Fever and Congenital Heart Disease, J.A.M.A. 151:141, Jan. 1953. 28. Keefer, C. S., Pennsylvania M. J. 55:1177, Dec. 1952. 29. Kerrell, W. E., J.A.M.A. 150:1450, Dec. 1952. 30. Levy, D. F., Connecticut State M. J. 16:899, Dec. 1952. 31. Romansky, M. J. and Kelser, G. A., J.A.M.A. 150:1447, Dec. 1952. 32. Thomas L., Minnesota Med. 35:1105, Dec. 1952. 33. Jones, C. C., J. Iowa M. Soc. 42:533, Nov. 1952. 34. Reimann, H. A., Postgrad. Med. 12:255, Sept. 1952. 35. Bunn, P. A., N. Y. State J. Med. 52:2005, Aug. 1952. 36. Finland, M., New England J. Med. 247:557, Oct. 1952. 37. Babione, R. W. et al., U. S. Armed Forces M. J. 3:973, July 1952. 38. Hansen, A. E., South. M. J. 45:423, May 1952. 39. Dowling, H. F., G. P. 5:53, Feb. 1952. 40. Rhoades, P. S., G. P. 5:67, Feb. 1952. 41. Dowling, H. F. and Lepper, M. H., Med. Clin. North Amer., Jan. 1952, p. 247. 42. Karelitz, S. and Schifrin, N., Postgrad. Med. 11:17, Jan. 1952. 43. Panel Discussion, Pennsylvania M. J. 55:42, Jan. 1952. 44. Flippin, H. F. et al., J.A.M.A. 147:918, Nov. 1951. 45. Massell, B. F., Mod. Concepts Cardiovas. Dis. 20:105, Sept. 1951. 46. Weinstein, L., Boston Med. Quarterly 2:1, Sept. 1951. 47. Massell, B. F. et al., J.A.M.A. 146:1469, Aug. 1951. 48. Finland, M., Bull. New York Acad. Med., 27:199, April 1951. 49. Wheatley, D., Brit. M. J. 1:703, March 1951. 50. Keefer, C. S., Postgrad. Med. 9:101, Feb. 1951. 51. Bunn, P. A. et al., J.A.M.A. 144: 1540, Dec. 1950. 52. Weinstein, L. and Perrin, T. S., J. Pediat. 47:844, Dec. 1950. 53. Keefer, C. S., Am. J. Med. 7:216, Aug. 1949. 54. Robinson, J. A., Hirsch, H. L. and Dowling, H. F., Am. J. Med. 4:716, 1948. 55. Barach, A. L. and Garthwaite, B., Ann. Allergy 5:297, Aug. 1947. 56. Herrold, R. D., J. Urol. 57:897, May 1947. 57. White, H. J., Lee, M. E. and Alverson, C., Proc. Soc. Exper. Biol. & Med. 62:35, 1946. 58. Baumann, F. et al., J. Allergy 17:264, Sept. 1946. 59. Gamble, T. O. et al., Am. J. Obst. & Gynec. 50:514, Nov. 1945. 60. Woofter, A. C. and Hoffman, O. E., J. Iowa M. Soc. 35:189, May 1945.

'PENTIDS'® IS A SQUIBB TRADEMARK

**SQUIBB** Squibb Quality—the Priceless Ingredient




# PROGRAM

## FIFTY-THIRD ANNUAL MEETING WYOMING STATE MEDICAL SOCIETY

**Jackson Lake Lodge—Moran, Wyoming**

**June 28, 29, 30 — July 1, 1956**

**Headquarters — Jackson Lake Lodge**

### THURSDAY, JUNE 28

**Afternoon**

2:00—Council Meeting.

3:00-5:30—Registration.

5:30-6:30—President's Reception (Cocktails; Introduction of Guest Speakers).

**Evening**

6:30—Dinner (Informal).

8:00—Smoker for Men.

8:00—Mixer for Wives.

8:00—Movie—"The Sea Around Us"—Courtesy of RKO Radio Pictures, Inc., and Fox Intermountain Theatres.

### FRIDAY, JUNE 29

**Morning**

Presiding: Robert T. Porter, M.D.
Greeley, Colorado
President, Colorado State Medical Society

8:30—"Present Day Therapy for Shock of Surgical Patients"—John Lundy, M.D., Head of the Section on Anesthesia, Mayo Clinic, Rochester, Minnesota.

9:00—"Vascular Trauma and Traumatic Aspects of Hematuria"—Ben Eiseman M.D., Chief of Surgical Service, VA Hospital, and Associate Professor of Surgery, University of Colorado School of Medicine, Denver.

9:30—"Treatment of Fractures of Lower Leg"—Roger Anderson, M.D., Senior Consultant in Orthopedics, University of Washington Medical School, Seattle.

10:00—Intermission.

10:30—"Early Treatment of Maxillofacial Injuries"—Jerome Hilger, M.D., Clinical Associate Professor of Otolaryngology, Department of Medicine, University of Minnesota, Minneapolis.

11:00—"Use of Adrenocortical Hormones as Anti-Inflammatory Agents"—Thomas F. Dougherty, Ph.D., Professor and Head of Department of Anatomy, University of Utah College of Medicine, Salt Lake City.

11:30—"Diagnosis of Common Hand Injuries"—Paul J. Preston, M.D., Orthopedic Service, Oak Knoll Naval Hospital, Oakland.

**Afternoon**

12:30-1:30—Lunch and Question and Answer Period.

2:30—House of Delegates Meeting.

**Evening**

6:00—Cocktails.

7:00—Banquet—Elmer Hess, M.D., Speaker; 1955-56 President, American Medical Association.

### SATURDAY, JUNE 30

**Morning**

Presiding: Stuart W. Adler, M.D.,
Albuquerque; President, New Mexico Medical Society

8:30—"Ovarian Tumors in Women Under Forty"—H. S. Morgan, M.D., Clinical Associate Professor, University of Nebraska College of Medicine, Lincoln.

9:00—"Anesthesia for the General Practitioner"—John Lundy, M.D.

9:30—"Importance and Interpretation of Routine Blood Counts"—Matthew Block, M.D., Associate Professor of Medicine, University of Colorado School of Medicine, Denver.

10:00—"Treatment of Rheumatoid Arthritis"—Russell L. Cecil, M.D., Professor of Clinical Medicine Emeritus, Cornell University Medical College, New York City.

10:30—Intermission.

11:00—"Common Congenital Heart Lesions in Children—Diagnosis and Treatment"—S. Gilbert Blount, M.D., Associate Professor of Medicine and Director, Cardiovascular Pulmonary Laboratory, University of Colorado School of Medicine, Denver.

11:30—"Vertigo"—Jerome Hilger, M.D.

12:00—"Function of University of Wyoming in Medical Education"—L. Floyd Clarke, Ph.D., Head, Department of Zoology and Physiology, University of Wyoming, Cheyenne.

**Afternoon**

12:45—Lunch and Question and Answer Period.

2:00—Pfizer Fishing Derby (wives and kiddies invited).

**Evening**

7:00—Pfizer Buffet Supper, Dancing and Square Dancing.

## SUNDAY, JULY 1

**Morning**

Presiding: J. S. Hellewell, M.D.
Evanston, Wyoming
President-Elect, Wyoming State Medical Society

8:30—"Physiology of Iron in Relation to Therapy With Iron"—Matthew H. Block, M.D.

9:00—"Management of Breech Presentations"—Harold S. Morgan, M.D.

9:30—"Diagnosis of Relative Adrenocortical Insufficiency"—Thomas F. Dougherty, Ph.D.

10:00—Intermission.

10:30—"Pulmonary and Extra Pulmonary Tuberculosis in Children"—Sidney H. Dressler, M.D., Medical Director of the National Jewish Hospital, Denver.

11:00—"Treatment of Osteoarthritis"—Russell L. Cecil, M.D.

11:30—"Management of Low Back Ache"—Roger Anderson, M.D.

12:00—"A Practical Outline in the Treatment of Alcoholics"—James W. Sampson, M.D., Sheridan.

**Afternoon**

12:30—Lunch and Question and Answer Period.

1:45—House of Delegates Meeting.

---

## PROGRAM

### WOMAN'S AUXILIARY

**Thursday, June 28**

Afternoon

2:30—Registration.

5:30—President's Reception and Cocktail Party.

6:30—Dinner, followed by Women's Mixer.

**Friday, June 29**

Morning

9:30-11:00—Coffee—Northwest Medical Auxiliary, Hostesses.

10:00—Executive Board Meeting.
No Planned Luncheon.

Afternoon

2:00—General Meeting of Auxiliary.

**Evening**

6:00—Cocktails.

7:00—Banquet—Orchestra—Entertainment.

**Saturday, June 30**

12:00—Noon Luncheon—Address by Mrs. Robert Flanders, Manchester, N. H., 1956-57 President, Woman's Auxiliary to American Medical Association.

4:00—Past Convention Board Meeting.

7:00—Pfizer Dinner—Informal Evening.

## *Obituary*

### DR. JAMES G. STEWART DIES

Dr. James G. Stewart, 74, of Sheridan, died on April 30, 1956.

Born at West Union, Iowa, he graduated from Northwestern University Medical School in 1907. In 1908 he located at Grover, Colorado, and remained there until 1925, when he was licensed in Wyoming and moved to Sheridan. Dr. Stewart was a general practitioner and a member of his constituent medical organizations. He was preceded in death by his wife in 1947.


## *Component Societies*

### LARIMER COUNTY

Dr. Mason Morfit, Denver, discussed Cancer of the Thyroid at the regular dinner meeting held in Loveland on Wednesday, May 2. The next meeting is scheduled to be held in Estes Park, June 6. W. S. ABBEY, Secretary.

### PROWERS COUNTY

The regular meeting of the Prowers County Medical Society was held May 9 in Lamar. Drs. George R. Buck, President-Elect; Lawrence D. Buchanan, Trustee, and Lloyd K. Wright, Comprehensive Care Committee, were the guests. After dinner these doctors discussed Society finances, policies and other matters of general interest.

EDWIN C. LIKES, Secretary.

## *Obituaries*

### ISAIAH KNOTT

Dr. Knott died April 1, 1956. He was born in 1873 and received his M.D. from Missouri Medical College, St. Louis. Together with his brother, Dr. A. W. Knott, he moved to Montrose, Colorado, from Missouri over fifty years ago. He had practiced in Montrose continuously since that time, though for the last three years he did not maintain an office.

Dr. Knott's family has contributed a good many medical practitioners—his father, a sister and a brother (Dr. A. W. Knott of Montrose, deceased), a nephew, and the three sons of his nephew.

Dr. Isaiah Knott's wife died about fifteen years ago in Montrose. Survivors are his two sons and two daughters.

### CHARLES O. GIESE

Dr. Charles O. Giese passed away April 24, 1956, in Colorado Springs. He was born in California in 1875 and received his medical education at St. Louis University School of Medicine. He had been located in Nebraska prior to establishing his practice in Colorado in 1910. Dr. Giese was President of the Colorado Tuberculosis Association during 1935-36.


**THE EMORY JOHN BRADY HOSPITAL**

401 Southgate Road COLORADO SPRINGS, COLORADO
MElrose 4-8828

For the care and treatment of Psychiatric disorders.
Individual and Group Psychotherapy and Somatic Therapies.
Occupational, diversional and outdoor activities.
X-ray, Clinical Laboratory and Electroencephalography.

E. JAMES BRADY, M.D., *Medical Director*
C. F. RICE, *Superintendent*

FRANCIS A. O'DONNELL, M.D.
THOMAS J. HURLEY, M.D.
GEORGE E. SCOTT, M.D.
ROBERT W. DAVIS, M.D.

# 2 OLD FRIENDS

## in the treatment of Peptic Ulcer

## are now together in

## One Tablet to form *TIZAMAG**

*... An "IDEAL ANTACID"*

***TIZAMAG***

(brand of calcium carbonate and magnesia). One tablet is approximately equivalent to 8 ounces of milk in hydrochloric acid neutralizing ability.

***TIZAMAG***

Is *pleasant* to *taste, inexpensive, readily available,* in the handy pocket container; equally effective alone or with food.

***INCIDENTALLY!***

*TIZAMAG* is a big help to the overweight patient. The relief of gastric acidity with pleasant tasting Tizamag allays appetite. Write for a summary of recent literature, and the handy pocket container of TIZAMAG.

*TIZAMAG (tease-a-mag) AN IDEAL ANTACID

***G. BERNON COMPANY***

846 BROADWAY • DENVER, COLORADO

Famous for over 60 years
as Denver's finest
and purest
drinking water

deep rock

ARTESIAN WATER

- Endowed by Nature with the ideal amount of fluorine, 1.3 parts per million
- Contains no added chemicals
- Recommended by Doctors for baby formulas, stomach and kidney disorders

DISTILLED WATER

- Scientific distilling process removes all minerals
- Aerated, to remove flat taste of other distilled waters
- Recommended by Doctors for baby formulas, allergies, prescriptions and sterilizing instruments

DEEP ROCK WATER CO. TA 5-5121
614 27th STREET DENVER, COLORADO

Cook County Graduate
School of Medicine

INTENSIVE POSTGRADUATE COURSES
STARTING DATES—SUMMER & FALL, 1956

**SURGERY**—Surgical Technic, Two Weeks, July 23, August 6. Surgical Anatomy and Clinical Surgery, Two Weeks, September 24. Surgery of Colon and Rectum, One Week, September 17. General Surgery, Two Weeks, September 10. Thoracic Surgery, One Week, October 1. Esophageal Surgery, One Week, September 24. Breast and Thyroid Surgery, One Week, October 22. Fractures and Traumatic Surgery, Two Weeks, October 15.

**GYNECOLOGY AND OBSTETRICS**—Obstetrics and Gynecology, Three Weeks, October 22. Office and Operative Gynecology, Two Weeks, September 17. Vaginal Approach to Pelvic Surgery, One Week, September 10.

**MEDICINE**—Electrocariography and Heart Disease, Two-Week Basic Course, July 9. Internal Medicine, Two Weeks, September 24. Gastroscopy and Gastroenterology, Two Weeks, September 10. Gastroenterology, Two Weeks, October 22. Dermatology, Two Weeks, October 15.

**RADIOLOGY**—Diagnostic X-Ray, Two Weeks, September 17. Clinical Uses of Radioisotopes, Two Weeks, October 8.

**UROLOGY**—Two-Week Course October 8. Cystoscopy, Ten Days, by appointment.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL

ADDRESS: REGISTRAR, 707 SOUTH WOOD STREET, CHICAGO 12, ILLINOIS

### ALBERT J. ARGALL

Dr. Argall died May 1, 1956, in St. Joseph's Hospital, Denver. He was born in England May 1, 1886, and came to the United States with his family in 1888. He was educated in Colorado, graduating from the University of Colorado Medical School in 1910. He then did graduate work for his specialty at Johns Hopkins University.

After serving in the Navy during World War I, Dr. Argall returned to Denver in 1921 to take up his practice in eye, ear, nose and throat. He practiced for thirty-five years, until his death. He was a fellow of the American College of Surgeons, a member of state and local medical societies, and a member of the Colorado Otolaryngological Society.

Survivors are his widow, Mabel, two daughters and two grandchildren.

### NATHAN B. NEWCOMER

Word was received in Denver Saturday, May 5, of the death in San Diego, California, of Dr. Nathan B. Newcomer, retired Denver physician.

Friends said Dr. Newcomer died unexpectedly Saturday noon after suffering a stroke in the Southern California city.

Both Dr. Newcomer and his wife, Elizabeth, were widely known practicing radiologists in Denver before their retirement in 1950. Mrs. Newcomer died in 1952.

Born in Illinois, Dr. Newcomer received his medical degree from the old Denver and Gross Medical College. He married Dr. Elizabeth Horneman and the couple first practiced in the rugged country of Northern Wyoming.

They returned to Denver in 1925 to specialize in radiology.

Dr. Newcomer was active in the Denver County Medical Society, the Colorado State Medical Society, American Medical Association, and Radiological Society of North America.

Surviving are a son, Nathan F. Newcomer of Palo Alto, California, with whom he made his home in recent years; a brother, Joe Newcomer, of Checotah, Oklahoma, and a nephew, Francis Flemmer, of Trinidad


## *News Briefs*

### WIESLEY WINS UTAH MEDICAL MERIT PLAQUE

Otto A. Wiesley, Chairman of the Utah Industrial Commission, received the third annual award of merit of the Utah State Medical Association for his "outstanding record in administration of the workmen's compensation and industrial disease laws."

A bronze plaque presented to him at a dinner in the Fort Douglas Club cited Mr. Wiesley's contributions to medical care, and his knowledge

PICKER X-RAY CORPORATION

wishes to announce the appointment of

MR. EMERY L. GRAY

as regional manager of the Rocky Mountain Area

1207 East Thirteenth Ave.
Denver, Colorado

Picker X-ray

Tel. AComa 2-7075

**The Southard School**

Intensive individual psychotherapy in a residential school, for children of elementary school age with emotional and behavior problems.

**The Menninger Children's Clinic**

Outpatient psychiatric and neurologic evaluation and consultation for infants and children to eighteen years.

**Department of Child Psychiatry**

**THE MENNINGER FOUNDATION**

**J. COTTER HIRSCHBERG, M.D., Director** **Topeka, Kansas; Telephone 3-6494**

**THE CHILDREN'S HOSPITAL ASSOCIATION**
**of DENVER**

NON-SECTARIAN—NON-PROFIT

Providing medicinal and surgical aid to sick and crippled children of the Rocky Mountain Region

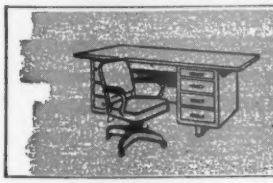
**Approved by The Joint Commission on Accreditation of Hospitals**

**NEWTON OPTICAL COMPANY**

GUILD OPTICIANS

309-16th Street Phone KEystone 4-0806 Denver

*Catering to Medical Profession Patronage*



*we value the business of the many doctors we serve*

**MERCHANTS OFFICE FURNITURE COMPANY**

1511 Arapahoe Street • AComa 2-2559
Denver, Colorado

of medical problems, which have assisted materially in helping to raise the standard of medicine in Utah, resulting in better medical care for the people of the state. The annual award of merit of the U.S.M.A. was presented in 1954 to the Salt Lake Tribune and William C. Patrick, medical editor, and the second to Gov. J. Bracken Lee.

## *Obituary*

### LEONARD H. TABOROFF

Leonard H. Taboroff, M.D., died April 16, 1956, in Honolulu, T. H.

Dr. Taboroff, who was associate professor of psychiatry at the University of Utah and Director of Utah Child Guidance Center, was vacationing with his wife and two daughters in Hawaii at the time of his death.

A native of Philadelphia, Pennsylvania, he came to Salt Lake City as director of the center in August, 1949. He became associate professor of psychiatry last year.

Dr. Taboroff received his Bachelor of Science degree from Franklin Marshall College, Lancaster, Pennsylvania, and his M.D. from Hahnemann Medical College, Philadelphia.

He was visiting psychiatrist at Primary Children's Hospital, attending psychiatrist at the Salt Lake Veterans' Hospitals, and psychiatric consultant for the Family Service Society. Many of his writings on child psychiatric problems have appeared in scientific publications.

Last year Dr. Taboroff was President of Intermountain Psychiatric Association and, at the time of his death, was a counselor of American Academy of Child Psychiatry and chairman of the Committee on Mental Health, Utah State Medical Association.

### IN MEMORIUM

Dr. Karl O. Nielson joined the Utah State Medical Association and Utah County Medical Society in 1938. With hearts full of sorrow and with a recognition to Him who knows all things and does all things for the best, the Utah State Medical Association and the Utah County Medical Society pause to share its grief and acknowledge the passing of our beloved friend and member, Dr. Karl O. Nielson. With a personality full of charm and kindliness, he added to the happiness of all with whom he came in contact and we are deeply conscious of the fact that his passing came as a severe loss to his family, his societies, his community and state and his countless friends, and we resolve to acknowledge the hand of the Lord and say with Him, "Thy will be done," and let it be said that the officers and members of the Utah State Medical Association and the Utah County Medical Society extend Mrs. Nielson and her family their sincere sympathy and order that this testimony be entered upon the official records of these Societies, signed and passed this 14th day of May, 1956, in Provo, Utah.

R. O. PORTER, President,
Utah State Medical Association;
C. M. SMITH, President,
Utah County Medical Society;
HAROLD BOWMAN,
Executive Secretary.


P.A.F. CASE pH4

(*Pulvis Antisepticus Fortior*)

**Improved**
**Antiseptic Douche Powder**

FORTIFIED—with Sodium Lauryl Sulfate and Alkyl Aryl Sulfonate.

DETERGENT—High surface activity in acid and alkaline media.

LOW SURFACE TENSION—Increases penetration into the vaginal rugae.

HIGH SURFACE ACTIVITY—Aids in destruction and dissolution of abnormal bacteria and organisms such as Trichomonas and fungus.

**Buffered to control a normal vaginal pH.**

ETHICALLY PKGED, net wt.
10 oz. .....$1.25

Mfd. by G. M. CASE LAB.,
San Diego, Calif.



"...WHEN CONTINUOUS DIURESIS IS MANDATORY TO CONTROL HEART FAILURE, NEOHYDRIN BECOMES THE SUPERIOR [ORAL] AGENT, SINCE THIS COMPOUND CONTINUES TO PRODUCE DIURESIS WHEN ADMINISTERED DAILY"*

*Moyer, J. H., and Hughes, W. M.: J. Chron. Dis. 2:678, 1955.

00656

## BETTER

results are obtained with STERANE[1]—3 to 5 times more active than hydrocortisone or cortisone.

## BREATHING

capacity is greatly enhanced. "Relief of symptoms is more complete and maintained for longer periods with relatively small doses."[2]

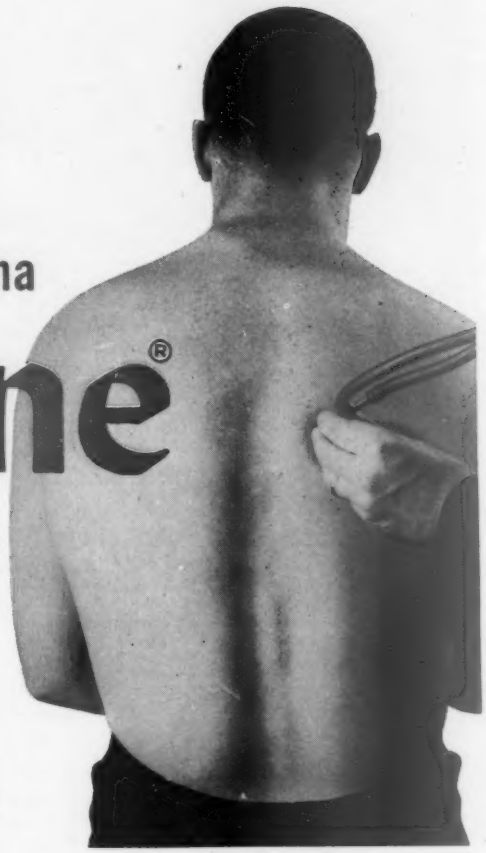
## BALANCE

of minerals and fluids usually remains undisturbed. This proves "especially advantageous in those patients with cardiac failure requiring therapy . . ."[3]

in bronchial asthma

# Sterane®

brand of prednisolone

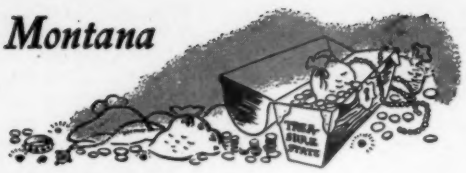


Supplied: White, 5 mg. oral tablets, bottles of 20 and 100. Pink, 1 mg. oral tablets, bottles of 100. Both deep-scored.

1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

**PFIZER LABORATORIES**
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

# Montana



## *News Briefs*

### NINTH ANNUAL INTERIM SESSION

Montana Medical Association's Ninth Annual Interim Session was held March 16 and 17 in Helena. M. Shelby Jared, M.D., Medical Director of the King County Medical Service Bureau and immediate Past President of the Washington State Medical Association, gave an address at the banquet entitled, "The Physician, the Government and Prepayment."

Past officers and Trustees of Montana Physicians' Service-Blue Shield who were honored at this banquet included **M. A. Shillington, M.D., Paul L. Eneboe, M.D., H. D. Huggins, M.D., J. C. Shilds, M.D., W. F. Hamilton, M.D., T. L. Hawkins, M.D., Mr. Noel Carrico, Mr. Eugene Burris, W. A. Treat, M.D., L. W. Brewer, M.D., F. L. McPhail, M.D., Otto G. Klein, M.D., H. T. Caraway, M.D., H. O. Drew, M.D., F. D. Hurd, MD, Mr. Jack Toole M. O. Burns, M.D.,** and **Mr. C. W. Groth.**

**NINTH ANNUAL INTERIM SESSION, MONTANA MEDICAL ASSOCIATION, MARCH 16 AND 17**

**Reading left to right: Edward S. Murphy, M.D., Missoula, President-Elect of the Montana Medical Association; Mrs. A. E. Ritt, President of the Montana Medical Association Auxiliary; George W. Setzer, M.D., President of the Montana Medical Association; H. W. Fuller, M.D., President of Montana Physicians' Service; Dr. Jared; The Honorable J. Hugo Aronson, Governor of Montana; J. J. McCabe, M.D., Secretary of the Montana Physicians' Service, and Father John J. O'Connor of Helena.**


*The Home With a Heart*

**THE FAIRHAVEN MATERNITY SERVICE**

*Denver's original refuge for unwed mothers since* 1915

**Strictly confidential—Finest Hospital, Obstetrical Care (American Medical Association)**

**MRS. RUTH B. CREWS, Supt. 3359 Leyden DExter 3-1411**

For pain—

Effective orally as well as parenterally
with relief lasting six to eight hours.

Levo-Dromoran 'Roche' is the most potent narcotic-analgesic presently available, natural or synthetic. It is practically as effective by mouth as by injection, and can therefore simplify nursing care. Has a margin of safety approximately equal to that of morphine, but with less tendency to induce constipation.

Levo-Dromoran® Tartrate - brand of levorphan tartrate

ROCHE
Original Research
in Medicine and Chemistry

## Visitors permitted

Your patients on Gantrisin can usually look forward to rapid recovery from bacterial infections. Gantrisin achieves high plasma and urine levels, minimizes the dangers of sensitization and overgrowth of fungi, and is well tolerated by patients of all ages. A wide range of pathogens are susceptible to this single, soluble, wide-spectrum sulfonamide.

Hoffmann - La Roche Inc · Nutley · N.J.

ROCHE

Gantrisin® 'Roche' - brand of sulfisoxazole

*Wondering . . .*

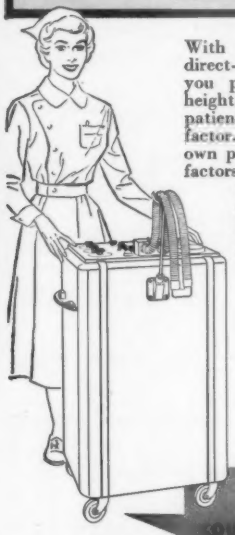
if that BMR test calculation was right?

THERE'S A NEW *surer* WAY . . .

**THE L-F BASALMETER**

***Self-Calculating***

**Basal Metabolism Apparatus**



With this new, self-calculating, direct-reading BMR apparatus, you put in four factors (age, height, weight and sex) and the patient puts in the fifth—the time factor. The BasalMeteR does its own precise timing, computes all factors and gives you, as soon as test is concluded, an accurate basal metabolic rate. NO CHARTS! NO SLIDE RULES! NO OXYGEN TANKS!

No "wondering" about human error with the BasalMeteR. At conclusion of test, you press a button and read the result in terms of a plus or minus in percentage of normal. It's AUTOMATIC! Send for descriptive literature, without obligation, *today!*

MAIL THIS COUPON *Today!*

**PHYSICIANS and HOSPITALS SUPPLY CO.**
**Minneapolis 3, Minn.**

Gentlemen: Please send me, without obligation, illustrated literature describing the new L-F BasalMeteR.

NAME.....

ADDRESS.....

CITY STATE.....



EVERY WOMAN WHO SUFFERS IN THE MENOPAUSE DESERVES "PREMARIN"

*widely used natural, oral estrogen*

AYERST LABORATORIES
New York, N.Y. • Montreal, Canada

5646

You.....can order REPRINTS of any feature article or advertisement appearing in *The Rocky Mountain Medical Journal*

The cost is very reasonable. For further information write to your Medical Journal business or editorial office, or to—

**PUBLISHERS PRESS**

*(Printers of The Rocky Mountain Medical Journal)*

**1830 Curtis Street, Denver, Colorado**

(Orders must be placed within 30 days of date of publication)

The COCKS-CLARK ENGRAVING CO.

PHOTOENGRAVERS
DESIGNERS

2200 ARAPAHOE ST.
DENVER 2, COLORADO

PROMPT SERVICE

# The Book Corner

## New Books Received

*New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.*

**Diagnosis and Treatment of Vascular Disorders:** By S. S. Samuels. Published by Williams and Wilkins, Baltimore, 1956. Price: $16.00.

**A Course in Practical Therapeutics:** By M. E. Rehfuss. Published by Williams & Wilkins, Baltimore, 1956. Price: $15.00.

**Diseases of the Chest:** By H. C. Hinshaw and L. H. Garland. Published by Saunders, Philadelphia, 1956. Price: $15.00.

**A Modern Pilgrim's Progress for Diabetics:** By G. G. Duncan. Published by Saunders, Philadelphia, 1956. Price: $2.50.

**The Neuroses in Clinical Practice:** By H. P. Laughlin. Published by Saunders, Philadelphia, 1956. Price: $12.50.

**The Truth About Cancer:** By Charles S. Cameron. Prentice-Hall, Inc., Englewood Cliffs, N. J., 1956. Price: $4.95.

**Therapy of Fungus Diseases:** By Thomas H. Sternberg and Victor D. Newcomer. Little, Brown & Co., Boston, 1955. Price $7.50.

**Bellevue Is My Home:** By Salvatore R. Cutolo. Curtis Pub. Co., Phila., 1955. Price: $4.00.

**Laboratory Tests in Common Use:** By Solomon Garb. Springer, New York, 1956. Price: $2.00.

**Modern Treatment Yearbook, 1956:** Edited by Sir Cecil Wakeley. Printed for the Medical Press by Bailliere, Tyndall & Cox, London, 1956. Price: $6.00.

**Gynecologic Cancer:** By James A. Corscaden, Ph.B., M.D. 2nd edition. Williams & Wilkins, 1956. Price: $10.00.

**A Handbook of Medical Hypnosis:** By Gordon Ambrose and George Newbold. Bailliere, Tyndall & Cox, London, 1956. Price: $5.00.

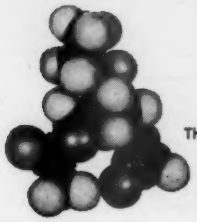
**Textbook of Medical Physiology:** By Arthur C. Guyton, M.D. W. B. Saunders Co., Phila., 1956. Price: $12.50.

*66 Years of Ethical Prescription Service to the Doctors of Cheyenne*

**ROEDEL'S**

**PRESCRIPTION DRUG STORES**

**CHEYENNE, WYOMING**



THE MILTOWN MOLECULE

## A tranquilizer well suited for prolonged therapy

# NO ORGANIC CONTRAINDICATIONS

## reported to date

- well tolerated, non-addictive, essentially non-toxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

*Indications: anxiety and tension states, muscle spasm.*

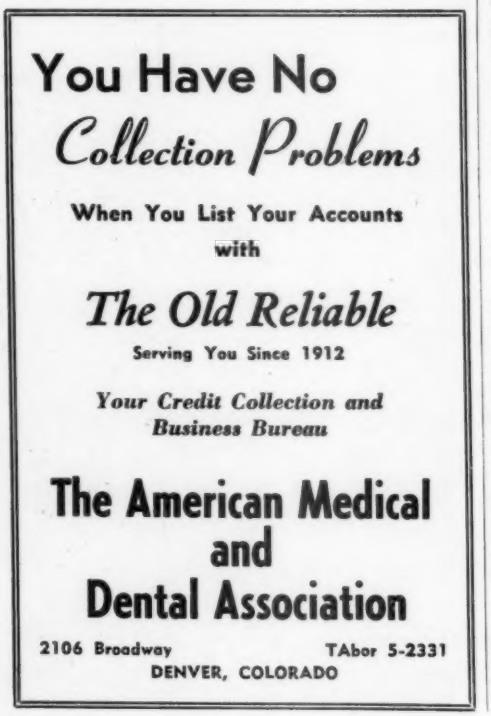
# Miltown®

the original meprobamate—2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

SUPPLIED: 400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.

*DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N. J.*

*Literature and Samples Available on Request*



**Electrocardiography; Fundamentals and Clinical Application:** By Louis Wolff, M.D. 2nd edition. W. B. Saunders Co., Phila., 1956. Price: $7.00.

**Clinical Recognition and Management of Disturbances of Body Fluids:** By John H. Bland, M.D. 2nd edition. W. B. Saunders Co., Phila., 1956. Price: $11.50.

## *Book Reviews*

**The Interpretation of the Unipolar Electrocardiogram:** By Gordon A. Myers. St. Louis, C. V. Mosby Co., 1956. 164 pages.

Those who have known about the manual that Dr. Gordon Myers used in his course in electrocardiography will be happy that it is now generally available. It is an excellent manual and a must for anybody reading electrocardiograms. It is not a substitute for a text on electrocardiography and without the Myers' personality to make it live, it can be difficult reading, or at least difficult "remembering." It is the reviewer's impression that many of the explanations and concepts in the manual are teleological, and in some instances basic concepts are somewhat manhandled. This does not detract from the practical value of the presented material.

A. RAVIN, M.D.

**Hypothermic Anesthesia:** By Robert W. Virtue. Charles C. Thomas, 1955. 62 pages.

Dr. Virtue is well qualified to write on this subject. He has been engaged in research and its clinical application for some time now and has administered this type anesthesia to a relatively large number of patients.

This work or essay deals with early observation and uses of the method. Then quite extensively he discusses recent observations of its physiologic effects on patients. The latter chapters deal with present thought on the clinical application of the method and technic of usage.

Finally, he outlines how much is not known or incompletely known of the method.

For anyone contemplating the use of hypothermic anesthesia, this monograph is a must. For anyone engaged in the practice of anesthesiology it is fascinating reading.

JOHN C. McAFEE, M.D.

**The Physician and His Practice:** By Joseph Garland, M.D. Boston, Little, Brown & Co., 1954. 270 pages.

"The Physician and His Practice" has been planned as a source book of information regarding his career rather than as a detailed guide for the young doctor, who, his internship, residency, or military service completed, contemplates the fascinating fields that his training has laid open to him. It is a book that practitioners of long standing may also find of value as they review their methods of practice, their material equipment, and the resources of the communities in which they live and work.

A proper emphasis is placed on the character and personality of the physician and the standards that are expected of him—and his wife—in relation to the two important circles in which they move: the intimate family circle and the larger community one. The fields that medicine now encompasses are here defined, with discussions of the various types of activities that they offer, the necessity of hospital affiliations, the place of organization and organizations in the profession, and the physician's need for continued study—for gaining knowledge and for imparting it.

# pronounced

# MUSCLE-RELAXING ACTION

# Equanil*

MEPROBAMATE

(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

LICENSED UNDER U.S. PATENT NO. 2,724,720

**For significant relief in myositis, osteoarthritis, backstrain, and related conditions marked by:**

- ***Muscle spasm***
- ***Stiffness and tenderness***
- ***Restriction of motion***
- ***Pain***

As a superior muscle-relaxant, EQUANIL offers predictable action and full effectiveness on oral administration. It does not disturb autonomic function and is relatively free from gastric and other significant side-effects. Its anti-anxiety property provides important correlative value.

Usual dosage: 1 tablet t.i.d. The dose may be adjusted either up or down, according to the clinical response of the patient.

Supplied: Tablets, 400 mg., bottles of 50.

Wyeth®

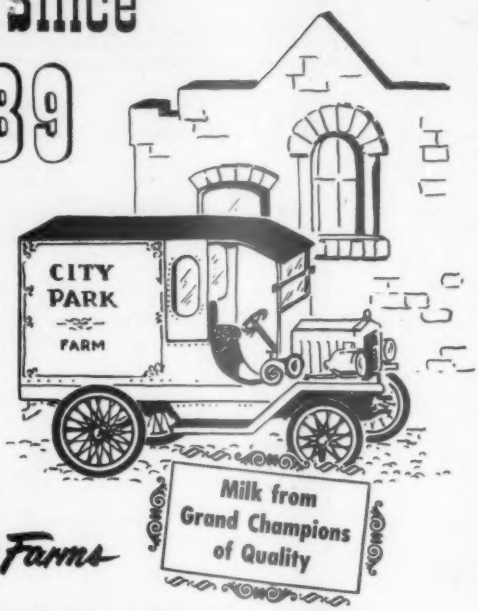
Philadelphia 1, Pa.

anti-anxiety factor
with muscle-relaxing action
...relieves tension

*TRADEMARK

# Serving Denver Since ...1889

...and even in those early days, Denver doctors learned to rely on milk from City Park Farm. Today's City Park-Brookridge milk is the product of 67 years of constant improvement... improved through experience, knowledge, and continual use of the most modern processing equipment. Since 1889, our reputation for quality has been our most cherished possession.




*City Park · Brookridge Farms*

**Office and Plant, 5512 Leetsdale Drive • Farm, Brighton, Colorado**

---


# Trasentine®-Phenobarbital

**CIBA**
*Summit, N. J.*

*integrated relief...*
mild sedation
visceral spasmolysis
mucosal analgesia

**TABLETS** *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

THIS IS HOW

# Rauwiloid®

The original alseroxylon fraction of India-grown Rauwolfia serpentina, Benth.

## Differs

from all other Rauwolfia preparations

### *Higher Clinical Efficacy*

Rauwiloid represents the balanced, mutually potentiated actions[1] of several Rauwolfia alkaloids, of which reserpine and the equally antihypertensive rescinnamine have been isolated. Hence, contrary to reports from some quarters, reserpine is not the only active principle of the Rauwolfia plant. Rauwiloid contains *all* the active principles, but it is freed of the undesirable dross of the crude Rauwolfia root.

### *Greater Safety*

No single commercially available alkaloid can provide the full efficacy of Rauwiloid together with Rauwiloid's low incidence/low intensity of side actions.[2] For example, mental depression is "much less frequent with alseroxylon..."[2] Rauwiloid is safely used even in the presence of cardiac, renal, and cerebrovascular complications of hypertension.

*Antihypertensive*

*Bradycrotic*

*Tranquilizing*

### *Simplified Dosage*

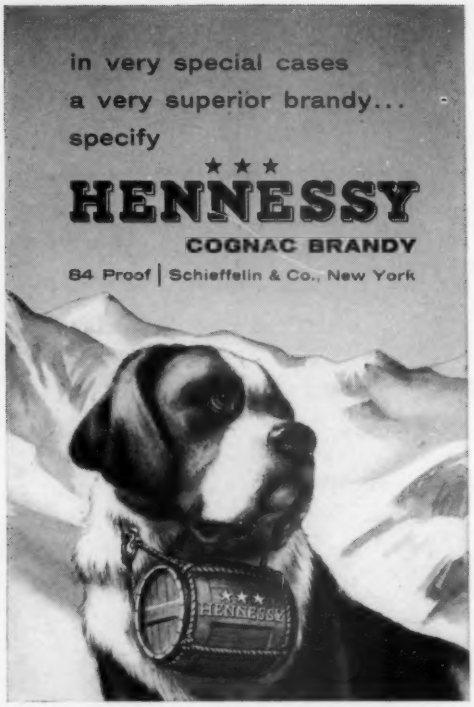
Dosage is simple...merely two 2 mg. tablets at bedtime. When desired effect has been obtained, one tablet per day often suffices.

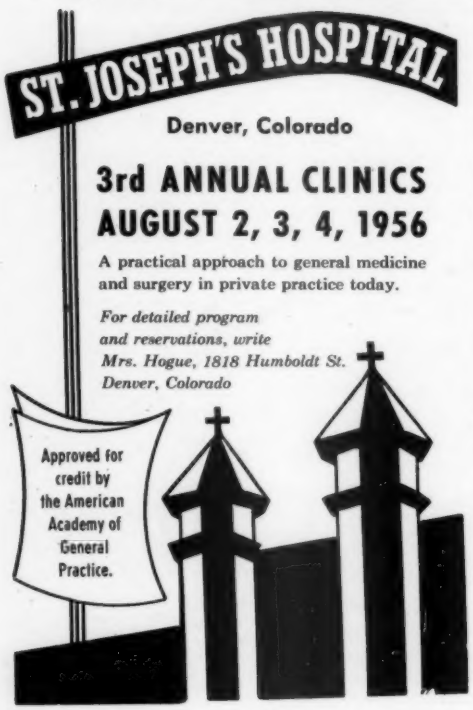
1. Cronheim, G., and Tookes, I. M.: Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. 96:530 (Oct.) 1955.

Riker

LOS ANGELES




Eighteen well-known authorities, each in his own field, have contributed to make this book a series of chapters on pertinent topics. It is well written, concise, and worthy of any physician's time.

LLOYD O. SHIELDS, M.D.

---

**Diseases of the Chest:** By H. Corwin Hinshaw and L. Henry Garland. Philadelphia, Pennsylvania, W. B. Saunders Co., 1956.

This is an excellent presentation of practically the whole gamut of pulmonary disease. It is organized well with proportionally more attention devoted to the more frequently encountered conditions. It is profusely illustrated with roentgenograms which are reproduced more clearly than usual.

Of first importance is the fact that the entire volume conveys thoroughly modern concepts of pathological conditions, making it a very valuable text for students and a ready reference for the internist or surgeon interested in chest disease.

WILLIAM B. CONDON, M.D.

---

**Proctologic Anatomy:** By R. V. Gorsch, M.D.

This is the second of Dr. Gorsch's books on the anus, rectum, and sigmoid colon, the first being published as "Perineal Pelvis Anatomy." Dr. Gorsch is probably the foremost anatomist in this field, which combined with his experience in the actual practice of procology, and in the postgraduate teaching field, makes his book highly reliable. The purpose of the second edition was to consolidate in one volume the modern and generally accepted concepts of the pelvis, pelvic floor, anorectal musculature, rectum and sigmoid, in complete detail. While detailed, it is still presented in understandable sequence, helped by the excellent and profuse illustrations and photographs, and is a marked improvement over the first edition.

C. B. WILLS, M.D.

---

**Hypnotic Suggestion:** By S. J. Van Pelt. Philosophical Library, New York, 1956. Price: $2.75.

S. J. Van Pelt's thesis is a handy little book, which offers an explanation of the hypnotic process, a theory about the origin of psychoneurosis and describes a working plan for hypnotherapy of psychoneurosis. In hypnosis, he says, all "units" of mind power are channeled into one direction without leaving any mind power to take notice of other things. Success or failure of hypnosis depends on ability to concentrate into one direction.

The theory about the origin of psychoneurosis is based on an original incident which, though forgotten, is starting a vicious circle of tension-unpleasant symptoms-more fear-more symptoms-tension.

The author's method of treatment consists of reaching a light hypnotic stage and giving the patient a post-hypnotic suggestion to bring up the incident which started his vicious circle. Relaxation by hypnosis, then realization of causes of trouble, will bring about re-education—at which therapy is aimed.

Apparently, the author is quite successful with his method and cuts down on time necessary to dig out deep-seated fears. It remains to be seen how it works in the hands of other practitioners. The method seems to be attractive. The thesis is short and clear, not sensational in form, description and promises. Worth trying.

LESLIE GRAY, M.D.

ZENITH

NOW 4 AND 5 TRANSITOR HEARING AIDS
*Priced from*
**$50 to $150**
By Makers of world-famous Zenith Radios, FM, Television Sets
**Bone Conduction Devices Available at Moderate Cost**

*The New Smallest Zenith Ever—Crusader Model—Can Be Worn on a Tie Clip*

**M. F. TAYLOR LABORATORIES**
*Denver's Oldest Hearing Aid Dealer*
**717 Republic Bldg., Denver**
**MAin 3-1920**

We are available when you need us
Open 9 A. M. to Midnight — 24 hour-a-day phone Service

9240 E. Colfax Ave.

— L K —
**PROFESSIONAL**
**Pharmacy**

Drive-Up Window Service

. . . Our large prescription volume insures FRESH drugs . . . Being specialists in our profession insures SERVICE

PHONE EM. 6-1531

FREE DELIVERY

***Specialists on***
**ARTIFICIAL EYES**
**DENVER OPTIC COMPANY**

Serving the doctor and his patient with the finest in natural appearing artificial eyes since 1906. Plastc eyes made to order. Largest selection of glass and plastic eyes in America. Specialists in building eyes for all types of implants. Write or phone for full details.

330 University Bldg., 910 16th St., Denver 2
MAin 3-5638

specify
Lederle
**POLIOMYELITIS IMMUNE GLOBULIN**
(human)

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

**Geo. R. Thornton**
**Orthopedic Brace and Appliance Co.**
**936 East 18th Avenue AL. 5-2897**
**Braces, Belts and Trusses**

**Handbook of Toxicology, Volume I:** By W. S. Spector, ed. 408 pp. W. B. Saunders, Philadelphia, 1956. Price: $7.00.

This is an extensive compilation in tabular form covering the acute toxicities of a large number of solids, liquids and gases for laboratory animals. The book is the first of a series to be prepared under the direction of the Committee on the Handbook of Biological Data, Division of Biology and Agriculture, The National Academy of Sciences, and The National Research Council.

The principal contributor is Wolfgang F. von Oettingen, M.D., Ph.D., Chief Toxicologist of the National Institute of Health, Bethesda, who has an international reputation and has written many papers, monographs, and books on toxicology and related topics. There are twenty-eight reviewers, all of whom are well known in the field of pharmacology and toxicology.

This volume presents tabular data on the acute toxicity of various substances for several species of commonly used laboratory animals as determined by oral or parenteral administration or inhalation of fatal doses. Material included is of basic importance and from reliable sources. Many substances and their properties listed elsewhere also may be found herein. For ready reference in the tables opposite the drug name is given the species of animal(s), route of administration, dose (LD or $LD_{50}$, MLD, etc.) in mg./Kg, dosage range, vehicle or solvent, time of death and references to the original literature where more details may be found.

The book is of large size to accommodate the tabular material. The printing is excellent. There are no illustrations. Compounds listed in the tables may be found in the index by a serial number as well as by chemical name.

The handbook should be especially useful to specialists in pharmacology and toxicology. It represents the most complete and up to date book of this type known to the reviewer. Physicians will seldom have need for information of the type contained in this volume.

RICHARD W. WHITEHEAD, M.D.

---

**Electrocardiography:** By E. Grey Dimond. 261 pp. C. V. Mosby Co., St. Louis, 1954. Price: $14.00.

In his book, "Electrocardiography," E. Grey Dimond accomplishes in admirable fashion his purported intent of carrying the general practitioner and medical student from a totally uninitiated stage to a fairly sophisticated level. The format of the book is well developed, and the print as well as the illustrations are reproduced with clarity. The development and subsequent use of vector analysis in illustrating features of the electrocardiograms is a particularly refreshing approach when contrasted with the more arbitrary "pattern" analysis. References are given when they are mentioned, thus eliminating frequent hunting for the end of the chapter. Another excellent feature is the section on types of direct writing machines and the technic of making them work properly.

All in all, the book is a worthwhile addition to any basic library on electrocardiography, and particularly useful to those whose primary interest does not lie with cardiology, but who do wish a precise, understandable grounding and reference text for the interpretation of their own electrocardiograms.

G. D. W.

---

# *Rocky Mountain Cancer Conference*

***July 11 and 12, 1956***

***Denver***


Established 1894

**Paul Weiss**

**OPTICIAN**

**1620 Arapahoe Street**

**Denver, Colo.**

**SPACE**

**FOR MEDICAL MEN**

becomes available from time to time in Denver's exclusive Medical Building... The Republic Building. For details, call or write the building manager:

**KE 4-5271**

**THE REPUBLIC BUILDING CORP.**

1624 Tremont Place • Denver, Colorado

Immediate and Sustained

# TRANQUILLITY

NEW

## Reserpine c Mebaral®

TABLETS

*Each tablet contains:*

| | | |
|---|---|---|
| Reserpine | 0.15 mg. | *for hypothalamic action* |
| Mebaral | 30 mg. | *for cortical action* |

*Indicated in*

ANXIETY AND TENSION STATES
PREMENSTRUAL TENSION
MENOPAUSAL SYNDROME
ESSENTIAL HYPERTENSION
ANGINA PECTORIS
CORONARY OCCLUSION

DOSE: 1 tablet 3 times daily. • SUPPLIED: Bottles of 100 tablets.

*Relaxation* WITHOUT LOSS OF ALERTNESS

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Mebaral (brand of mephobarbital), trademark reg. U. S. Pat. Off.

*Better Flowers at Reasonable Prices*

*"Orders Delivered to Any City by Guaranteed Service"*

**Special attention given to floral tributes. Also Hospital Flowers**

**Call KEystone 4-5106**

Park Floral Co. Store

**1643 Broadway** **Denver, Colo.**

Classen Nursing Home

Bed and Ambulatory Patients
Men only, seniles and pensioners
Special diet and nursing care
Nurse on duty all times

**FR. 7-2090**
**1433 St. Paul**
**Denver 6, Colorado**

**LAKEWOOD**

The new Lakewood Medical Building offers you exclusive professional office space in an area of above average income residents, yet our lease cost is no higher than other less desirable areas. Free parking and lots of it. We will be able to custom-tailor a few of the remaining offices. Direct inquiries to Maury Strait,

**Lakewood Realty & Ins., BE. 3-4646**

**JENKINS-KEOGH BILL**

H.R. 2092 (Jenkins-Keogh) is a bill that would permit self-employed people to put as much as $5,000 per year into privately managed retirement funds, up to a total of $100,000, without paying tax upon the money until the time came when they wished to draw the money out again to use for living expenses.

Every doctor's wife and every self-employed individual should understand this proposal and should urge Congressmen to support it. Do you wish to manage your own life, or do you want the government's bureaucrats to do it for you? If doctors are given a chance to provide for their old-age security in such a fashion as is outlined in this bill, there will be no excuse for anyone's continuing to urge that they be compelled to undergo Social Security taxation.

Professional groups support this legislation, and as of now, the administration supports it too, though it has shown signs of being willing to substitute a proposal that would compel physicians' entrance into the Social Security system.—J. of the Iowa State Medical Society.

**THE FIGHT AGAINST MENTAL ILLNESS**

The year 1955 may well go down in history as a memorable milestone in the fight against mental illness. Certainly the past few years have seen a remarkable upsurge in interest and attention paid to various psychiatric illnesses and it would appear that this area of human suffering has finally become recognized in its true light.

Sigmund Freud began his epochal researches during the last quarter of the past century. Since then it has become increasingly clear that the majority of personality problems have their origins in the formative years of childhood. This means that if we are to win the fight against emotional illness we must provide our children with increasingly improved emotional environments so that they will grow into more mature individuals capable of doing an even better job with their own children.—Stuart M. Finch, M.D., in Temple University Medical Center Bulletin.

*Oculist Prescription Service Exclusively*

**SHADFORD - FLETCHER OPTICAL CO.**

*Dispensing Opticians*

**218 16th Street, AComa 2-2611 Main Office**
**3705 East Colfax (Medical Center Building). FLorida 5-0202**
**1801 High Street, FLorida 5-1815 2465 South Downing, SPruce 7-2424**
**DENVER, COLORADO**

**Stodghill's Imperial Pharmacy**

**DENVER'S OLDEST EXCLUSIVE PRESCRIPTION PHARMACY**

**INTELLIGENT SERVICE**

**319 16th St.** **TAbor 5-4231** **Denver, Colo.**

# RELIABLE DRUGGISTS

PATRONIZE DENVER'S INDEPENDENT DRUGGISTS

27 Years in the Heart of North Denver

**LUBIN'S DRUG**

LUBIN L. ORTIS, Owner

PRESCRIPTIONS ACCURATELY COMPOUNDED

*Free Delivery Service*

West 38th Ave. and Clay Denver, Colo.

Phone GLendale 5-1073

---

Kincaid's Rx Pharmacy

BE 3-4621

1024 W. COLFAX

*Quality Drugs* *Courteous Service*

Adjustable Crutches for Rent

Surgical Supplies

Drugs and Prescriptions

FREE DELIVERY IN LAKEWOOD AND METROPOLITAN DENVER

---

**Whittaker's Pharmacy**

*"The Friendly Store"*

PRESCRIPTION SPECIALISTS

West 32nd and Perry, Denver Colo.

Phone GLendale 5-2401

---

**HYDE PHARMACY**

ACCURATE PRESCRIPTIONS

Chas. W. Hyde, *Prop.*

Rocky Mountain Distributors for Sherman Biologicals and Pharmaceuticals

Almay Non Allergic Cosmetics

*Prompt Free Delivery*

KE. 4-4811 MA. 3-4566

1400 East 18th Avenue at Humboldt

DENVER, COLO.

---

**Bonita Pharmacy**

(Established 1921)

**Prescription Pharmacists**

6th Avenue at St. Paul Street

"RIGHT-A-WAY" SERVICE

GERALD P. MOORE, *Manager*

Phone FRemont 7-2797

---

**EARNEST DRUG**

**217 16th Street**

*Prescription Specialists*

Telephones KEystone 4-7237—KEystone 4-3265

FRESH — CLEAN — COMPLETE PRESCRIPTION STOCK

*Free Delivery*

---

WE WELCOME AND CATER TO THE MEMBERS OF THE MEDICAL PROFESSION

**CUMMINGS PHARMACY**

(Formerly Marty Drug Co.)

3301 E. COLFAX AT ADAMS

W. F. Cummings, Owner

PRESCRIPTIONS

CALL EA. 2-1590

A streamlined pharmacy for all your needs.

PROMPT FREE DELIVERY

---

## For Sale

Additional copies of the Directory Issue are available. $2.00 per copy. Write 835 Republic Building, Denver 2, or call AComa 2-0547.

**PATENTED WEDGE GIVES SUPPORT TO CENTER LINE OF BODY WEIGHT ★**

★ Insole extension and wedge at inner corner of heel where support is most needed.

- The patented arch support construction is guaranteed not to break down.
- Innersoles guaranteed not to crack or collapse.
- Foot-so-Port lasts designed and the shoe construction engineered with orthopedic advice.
- Conductive Shoes for surgical and operating room personnel. N.B.F.U. specifications.
- We are also the manufacturer of the Gear-Action Shoe designed by noted orthopedic surgeon.
- We make more shoes for polio, club feet and disabled feet than any other shoe manufacturer.

*Send for free booklet, "The Preservation of the Function of the Foot Balancing and Synchronizing the Shoe with the Foot."*

*Write for details or contact your local* **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

**Foot-so-Port Shoe Company, Oconomowoc, Wis.**
A Division of Musebeck Shoe Company

"...THE MERCURIALS HAVE PROLONGED THE WORKING PERIOD AND LIFE SPAN OF COUNTLESS SUFFERERS FROM CONGESTIVE HEART FAILURE..."*

TABLET
**NEOHYDRIN®**

*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

00755

**Upjohn**
KALAMAZOO

indicated in most conditions in which oral cortisone or hydrocortisone is effective. Available in 2.5 mg. tablets in bottles of 100, and in 5 mg. tablets in bottles of 30, 100, and 500. Usual dosage is ½ to 1 tablet three or four times daily

**Deltasone***

*Less sodium retention, less potassium depletion*

***Trademark for the Upjohn brand of prednisone (delta-1-cortisone)**


Again, Keleket sets the pace with a money-saving development. NOW—ALL UNITS—200 MA, 300 MA and 500 MA use the SAME TRANSFORMER and CONTROL which can be produced at a savings . . . passed on to you!

This unit may be installed permanently, even in a wall, with no worry about alterations . . . should your future technic requirements call for the higher capacity Multicrons.

By standardizing many parts of the world-famous Multicrons, Keleket is able to offer custom-built units . . . which fit your individual requirements exactly . . . at most attractive prices.

*The controls are rated as follows:*

DIAGNOSTIC
200 MA unit—125 KVP at any MA—25 to 200
300 MA unit—125 KVP at any MA—25 to 300
500 MA unit—125 KVP at any MA—25 to 500

THERAPY
All units—140 KVP to 10 MA

*WRITE FOR FREE LITERATURE*

*The* **KELLEY-KOETT** *Manufacturing Company*

205-5 WEST FOURTH STREET, COVINGTON, KY.

*The oldest name in X-ray*

# TECHNICAL EQUIPMENT CORPORATION

**2548 West Twenty-Ninth Avenue** **GLendale 5-4768**

**DENVER 11, COLORADO**

After Hours Call
**SPruce 7-0082 or WEst 4-4573**

**Camby says, "CAMBRIDGE DAIRY has been producing QUALITY MILK for Denver babies since 1892."**

*We Invite Your Inspection and Appreciate Your Recommendation*

SKyline 6-3651 690 So. Colorado Blvd.

***Don't miss important telephone calls*** . . . . . .

Let us act as your secretary while you are away, day or night: our kindly voice conscientiously tends your telephone business, accurately reports to you when you return.

**Telephone ANSWERING Service** CALL ALPINE 5-1414

## WANTADS

WANTED, E.E.N.T. Specialist and Internist. Board eligible or certified; equal partnership in progressive group, in Rocky Mountain Area. Box 96, Rocky Mountain Medical Journal, Denver 2.

AURORA—Four lots suitable for Medical Center building. Will build to suit tenants or will sell or lease to group. Casey Jones, 1545 9th Street, Boulder; Hillcrest 2-8467.

**WANTED**

**CITY-COUNTY HEALTH DIRECTOR, GREAT FALLS, MONTANA**

Immediate opening for the above position. Applicants should have had some educational background or experience in the field of Public Health. Personnel work under State Merit System classification and compensation schedule, State Retirement plan and Social Security.

**Send applications to: City-County Health Department, Civic Center Building, Great Falls, Montana**

WANTED: Certified or Board Eligible Ophthalmologist and Pediatrician in progressive group, Rocky Mountain Area. Box 94, Rocky Mountain Medical Journal, Denver 2.

FOR SALE: 100 M.A. Maxicon, X-Ray-Fluoroscopic Unit, Metabulator, miscellaneous office equipment. Drs. Berris & Friedman, 1100 East 18th Avenue, Denver 18, Colorado. MA. 3-4371.

LOCUM TENNENS for at least 5 months starting July 1st in Colorado. Write Dr. Harold Halvorson, Denver General Hospital, West 6th Avenue and Cherokee St., Denver.

IDEAL LOCATION for doctors near hospitals, medical library, No. 40 bus line. Will remodel unusually attractive offices to suit. Reasonable rent. Ample parking. Ready for immediate rental. 1819 Gilpin St. FRemont 7-0958 or FR. 7-1463.

WANTED: Physician interested in Internal Medicine. New ultra-modern 100-bed GM&S hospital. Modern 2-bedroom apartment available at nominal rent. Salary range from $8,900 to $14,000 depending upon qualifications. Our Chiefs of Medicine and Surgery are both Board men. Apply M. J. Robertson, M.D., Manager, Veterans Administration Hospital, Miles City, Montana.

WANTED: Associate by busy general practitioner in rich farm area within one hour's drive from Denver. Prefer recent graduate. Reply Box 101, Rocky Mountain Medical Journal, 835 Republic Building, Denver 2, Colorado.

FOR SALE: Picker Vertical Flouroscope. New 1950. Only a few hours operating use. Stored 1951 on departure military service. For quick sale, price $600.00. Dr. Anthony Reymont, Coronado Building, Santa Fe, New Mexico.

**H-O-W-D-Y**

Registered Trade Mark

Trade Mark

**BOB'S PLACE**

A Bob Cat for Service

CONOCO PRODUCTS

300 South Colorado Boulevard

Cow Town, Colo.

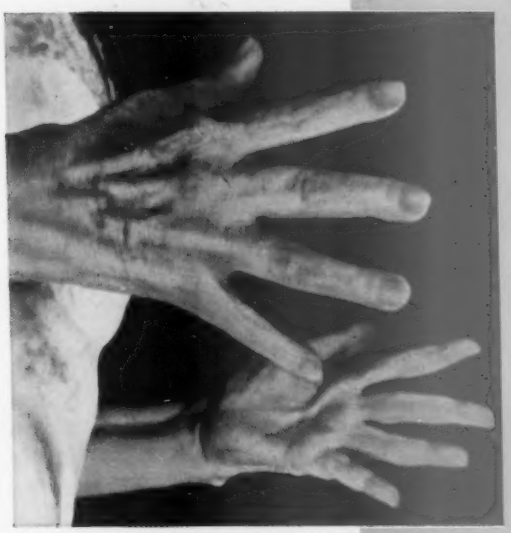
# in rheumatoid arthritis

## METICORTEN
(PREDNISONE)

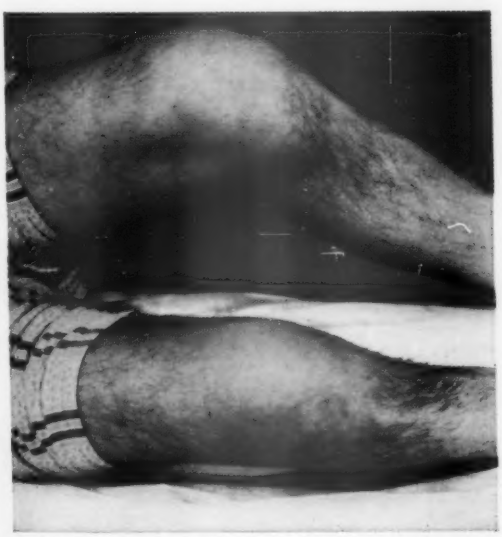
Schering

results—*excellent* · edema—*rare*

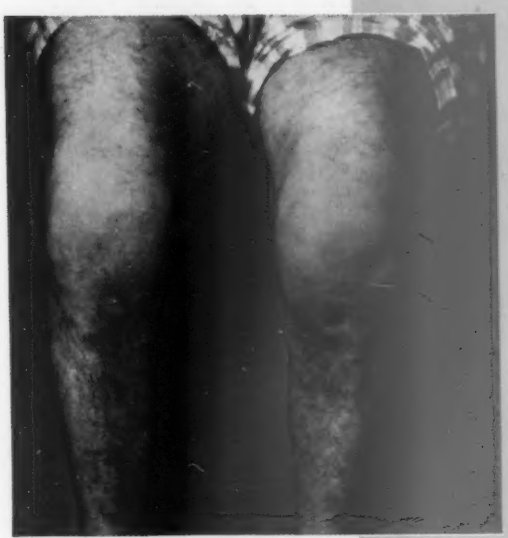
*Deformed hands of woman with rheumatoid arthritis before therapy. Unable to open hands.*



*After two weeks on* METICORTEN, *patient is free of pain and can open hands completely.*



*Acutely swollen, painful knees in man with rheumatoid arthritis before therapy.*



*After two weeks on* METICORTEN, *swelling of knees is gone and patient can walk without difficulty.*


# in corticosteroid therapy permits treatment of more patients

- rarely causes edema or electrolyte side actions
- 3 to 5 times more potent, milligram for milligram, than hydrocortisone or cortisone
- excellent relief of pain, swelling, tenderness; diminished joint stiffness—in rheumatoid arthritis
- excellent relief of bronchospasm, dyspnea, cough; increased vital capacity in asthma
- hormone benefits in respiratory allergies, inflammatory and allergic eye and skin disorders, collagen diseases

METICORTEN is available in 1 mg., 2.5 mg. and 5 mg. white tablets, and as 2.5 mg. and 5 mg. capsules.
METICORTEN,* brand of prednisone.

MC-J-614-386 *T.M.

# THE COLORADO STATE MEDICAL SOCIETY

**NEXT ANNUAL SESSION: SEPTEMBER 5-8, 1956; STANLEY HOTEL, ESTES PARK**

### OFFICERS, 1955-1956

Terms of Officers and Committeemen expire at the Annual Session in the year indicated. Where no year is indicated the term is for one year only and expires at the 1956 Annual Session.

**President:** Robert T. Porter, Greeley.

**President-Elect:** George R. Buck, Denver.

**Vice President:** Leo W. Lloyd, Durango.

**Constitutional Secretary** (three years): James M. Perkins, Denver, 1957.

**Treasurer** (three years): William C. Service, Colorado Springs, 1956.

**Additional Trustees** (three years): C. Walter Metz, Denver, 1956; Lawrence D. Buchanan, Wray, 1957; Thomas K. Mahan, Grand Junction, 1958; Terry J. Gromer, Denver, 1958.

(The above nine officers compose the Board of Trustees of which Dr. Porter is Chairman and Dr. Lloyd is Vice Chairman for the 1955-1956 year.)

**Board of Councilors** (three years): District No. 1: Osgoode S. Philpott, Denver, 1957; District No. 2: Roger G. Howlett, Golden, 1956; District No. 3: Harry C. Bryan, Colorado Springs, 1958; District No. 4: Paul R. Hildebrand, Brush, 1957; District No. 5: John D. Gillaspie, Boulder, 1957, Vice Chairman; District No. 6: Harvey M. Tupper, Grand Junction, 1958; District No. 7: Charles L. Mason, Durango, 1958; District No. 8: Herman W. Roth, Chairman, Monte Vista, 1956; District No. 9: Scott A. Gale, Pueblo, 1956.

**Board of Supervisors** (two years): William N. Baker, Chairman, Pueblo, 1957; Duane F. Hartshorn, Vice Chairman, Ft. Collins, 1957; Sam W. Downing, Secretary, Denver, 1956; J. Alan Shand, La Junta, 1956; George G. Balderston, Montrose, 1956; Lester L. Williams, Colorado Springs, 1956; Robert A. Hoover, Salida, 1956; Harold E. Haymond, Greeley, 1956; Lawrence W. Holden, Boulder, 1957; Robert C. Lewis, Jr., Glenwood Springs, 1957; Kenneth H. Beebe, Sterling, 1957; James S. Orr, Fruita, 1957.

**Delegates to American Medical Association** (two calendar years): Kenneth C. Sawyer, Denver, 1956; (Alternate, Irvin E. Hendryson, Denver, 1956); E. H. Munro, Grand Junction, 1957; (Alternate, Harlan E. McClure, Lamar, 1957).

**Foundation Advocate:** Walter W. King, Denver.

**House of Delegates:** Speaker, William B. Condon, Denver; Vice Speaker, Carl W. Swarts, Pueblo.

**Executive Office Staff:** Mr. Harvey T. Sethman, Executive Secretary; Mrs. Geraldine A. Blackburn, Executive Assistant; Mr. John W. Pompelli, Executive Assistant; 835 Republic Building, Denver 2, Colo.; Telephone AComa 2-0547.

**General Counsel:** Mr. J. Peter Nordlund, Attorney-at-Law, Denver.

# MONTANA MEDICAL ASSOCIATION

**NEXT ANNUAL SESSION: SEPTEMBER 13-15; GREAT FALLS.**

### OFFICERS, 1955-1956

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at the 1956 Annual Session.

**President:** George W. Setzer, Malta.

**President-Elect:** Edward S. Murphy, Missoula.

**Vice President:** John A. Layne, Great Falls.

**Secretary-Treasurer:** Theodore R. Vye, Billings.

**Assistant Secretary-Treasurer:** Park W. Willis, Jr., Hamilton.

**Executive Secretary:** Mr. L. R. Hegland, P. O. Box 1692, Office Telephone, 9-2585, Billings.

**Delegate to the American Medical Association:** Raymond F. Peterson, Butte.

**Alternate Delegate to the American Medical Association:** Paul J. Gans, Lewiston.

# NEW MEXICO MEDICAL SOCIETY

### OFFICERS, 1956-1957

Terms of officers expire at the Annual Session in the year indicated. Where no year or term is indicated, the term is for one year only and expires at the 1957 Annual Session.

**President:** Stuart W. Adler, Albuquerque.

**President-Elect:** Samuel R. Ziegler, Espanola.

**Vice President:** James C. Sedgwick, Las Cruces.

**Secretary-Treasurer:** Lewis M. Overton, Albuquerque.

**Executive Secretary:** Mr. Ralph R. Marshall, 223-24 First National Bank Building, Albuquerque; telephone 2-2102.

**Immediate Past President:** Earl L. Malone, Roswell.

**Councilors** (three years): W. E. Badger, Hobbs, 1957; W. D. Dabbs, Clovis, 1957; W. O. Connor, Jr., Albuquerque, 1958; L. L. Daviet, Las Cruces, 1958; Aaron Margulis, Santa Fe, 1959; Junius A. Evans, Las Vegas, 1959.

**Delegate to American Medical Association** (two years): H. L. January, Albuquerque, 1958; Alternate: Earl L. Malone, Roswell, 1958.

**Board of Supervisors:** A. J. Jenson, Hobbs, Chairman, 1957; W. J. Hossley, Deming, Secretary, 1957; Milton Floersheim, Jr., Raton, 1957; George W. Prothro, Clovis, 1957; A. D. Maddox, Las Cruces, 1958; G. A. Slusser, Artesia, 1958; Louis Levin, Belen, 1958; Jack Dillahunt, Albuquerque, 1958.

**New Mexico Physicians Service:** H. M. Mortimer, Las Vegas, 1957; H. L. January, Albuquerque, 1957; Fred Hanold, Albuquerque, 1957; L. L. Daviet, Las Cruces, 1957; O. C. Taylor, Jr., Artesia, 1957; C. S. Stone, Hobbs, 1957; R. P. Beaudette, Raton, 1958; R. V. Seligman, Albuquerque, 1958; Wendell Peacock, Farmington, 1958; Omar Legant, Albuquerque, 1958; Allen Haynes, Clovis, 1959; W. L. Minton, Lovington, 1959; J. P. Turner, Carrizozo, 1959; U. S. Marshall, Roswell, 1959; J. W. Hillsman, Carlsbad, 1959; Executive Director, Mr. L. J. LeGrave, 212 Insurance Building, Albuquerque, Phone 3-3188.

# THE UTAH STATE MEDICAL ASSOCIATION

### OFFICERS, 1955-1956

**President:** R. O. Porter, Logan.

**President-Elect:** James Z. Davis, Salt Lake.

**Past-President:** Charles Ruggeri, Jr., Salt Lake.

**Honorary President:** John Z. Brown, Sr., Salt Lake.

**Secretary:** Donald M. Moore, Ogden.

**Executive Secretary:** Mr. Harold Bowman, Salt Lake.

**Treasurer:** Alan P. Macfarlane, Salt Lake.

**Councilor, Box Elder Medical Society:** James H. Rasmussen, Brigham City.

**Councilor, Cache Valley Medical Society:** C. C. Randall, Logan.

**Councilor, Carbon County Medical Society:** L. H. Merrill, Hiawatha.

**Councilor, Central Utah Medical Society:** John B. Cluff, Richfield.

**Councilor, Salt Lake County Medical Society:** James F. Orme, Salt Lake.

**Councilor, Southern Utah Medical Society:** R. G. Williams, Cedar City.

**Councilor, Uintah Basin Medical Society:** T. R. Seager, Vernal.

**Councilor, Utah County Medical Society:** R. E. Jorgensen, Provo.

**Councilor, Weber County Medical Society:** I. Bruce McQuarrie, Ogden.

**Delegate to A.M.A., 1955-1957:** George M. Fister, Ogden.

**Alternate Delegate to A.M.A., 1955-1956:** Eliot Snow, Salt Lake.

**Editor of the Utah Section of the Rocky Mountain Medical Journal, 1957:** R. P. Middleton, Salt Lake.

# THE WYOMING STATE MEDICAL SOCIETY

**NEXT ANNUAL MEETING: JUNE 29, 30 AND JULY 1, 1956; JACKSON LAKE LODGE, MORAN**

**OFFICERS, 1955–1956**

**President:** R. I. Williams, Cheyenne.

**President-Elect:** Joseph Hollewell, Evanston.

**Vice President:** H. B. Anderson, Casper.

**Secretary:** Benjamin Gitlitz, Thermopolis.

**Treasurer:** C. D. Anton, Sheridan.

**Delegate to A.M.A.:** W. Andrew Bunten, Cheyenne.

**Alternate Delegate to A.M.A.:** Albert Sudman, Green River.

**Executive Secretary:** Arthur R. Abbey, Cheyenne, Box 2036.

**Councillors:** Glen O. Beach, 1956, Casper; Joseph Whalen, 1956, Evanston; Joseph E. Hoadley, 1957, Gillette, Francis A. Barrett, 1957, Cheyenne; Wm. Hinrichs, 1958, Douglas; Loran B. Morgan, 1958, Torrington; Nels Vickland, 1956, Thermopolis; R. I. Williams, Chairman (Ex-Officio), Cheyenne; Benjamin Gitlitz, Secretary (Ex-Officio), Thermopolis.

# COLORADO HOSPITAL ASSOCIATION

**OFFICERS, 1955–1956**

**President:** John R. Peterson, Larimer County Hospital, Fort Collins.

**President-Elect:** Sister Mary Jerome, Mercy Hospital, Denver.

**Vice President:** Hubert Hughes, General Rose Memorial Hospital, Denver.

**Treasurer:** M. A. Moritz, Denver General Hospital, Denver.

**Executive Secretary:** Richard P. Mac Leish, Denver.

**Executive Offices:** 1422 Grant Street, Denver 3.

**Trustees:** Robert A. Fontow (1956), University of Colorado Medical Center, Denver; Roy Prangley (1956), St. Luke's Hospital, Denver; Msgr. John R. Mulroy (1956), Catholic Charities, Denver; Roy Anderson (1957), Presbyterian Hospital, Denver; Harry Clark (1957), Southwest Colorado Memorial Hospital, Cortez; Elton A. Reese (1957), Alamosa Community Hospital, Alamosa; Louis Liswood (1958), National Jewish Hospital, Denver; Charles K. Levine (1958), Beth Israel Hospital, Denver; C. F. Fielden, Jr., (1958), Memorial Hospital, Colorado Springs; Louis I. Miller, M.D. (ex-officio), Colorado Hospital Service, Denver.

**Delegates:** Harley E. Rice, Porter Sanitarium and Hospital, Denver; Henry H. Hill, Alternate, Weld County General Hospital, Greeley.


**TAX EXEMPT SECURITIES**

*Need We Tell You . . .*

**That Federal Income Taxes take a considerable portion of your income?**

*So Why Not Talk To Us . . .*

**about dependable income from municipal securities. Because of tax concessions granted on income from these investments, individuals in the higher income brackets enjoy a greater yield than from fully taxable securities.**

***Write or call for more complete information regarding tax-free income.***


MOUNTAIN STATES
Securities Corporation
INVESTMENT BANKERS
ACOMA 2-4831
460 DENVER CLUB BUILDING DENVER 2, COLO.
SALT LAKE CITY • LAS VEGAS • GRAND JUNCTION

*Accuracy and Speed in Prescription Service*

**DORR OPTICAL COMPANY**

421 16th Street Denver, Colorado KEystone 4-5511

# Index to Advertisers




Established 1904

*Las Encinas*

PASADENA, CALIFORNIA

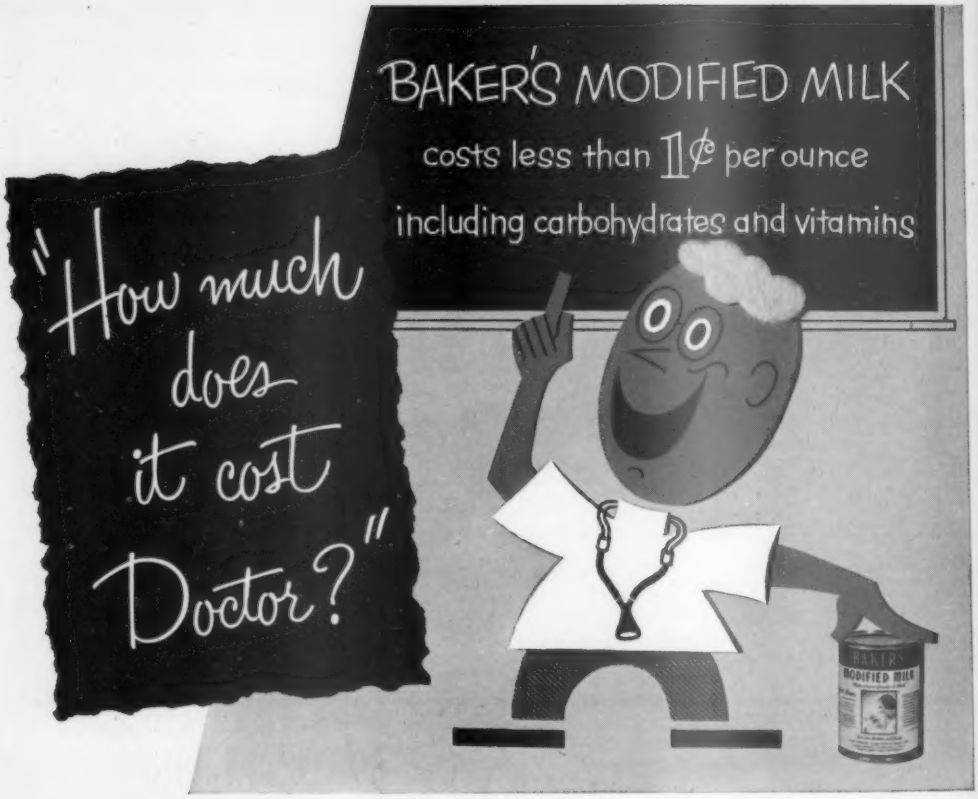
LAS ENCINAS, sheltered in its own landscaped park, is conveniently located in Pasadena. Fully equipped for the clinical study, diagnosis and treatment of medical and emotional problems. Full-time staff of certified specialists in surgery, medicine and psychiatry. Rooms, apartments and suites available in main building or attractive cottages.

MEDICAL DIRECTOR
CHARLES W. THOMPSON, M.D., F.A.C.P.

STAFF

CLIFTON H. BRIGGS, M.D., F.A.C.S.
ETHEL FANSON, M.D., F.A.C.P.
DOUGLAS R. DODGE, M.D.
HERBERT A. DUNCAN, M.D.
KENNETH P. NASH, M.D.
STEPHAN SMITH, III, M.D.
HARRIET HULL SMITH, M.D.
JOHN W. LITTLE, M.D.

WRITE FOR OUR ILLUSTRATED BOOKLET




## You have an economical answer
## BAKER'S MODIFIED MILK*

When a mother asks about the cost of a formula for her baby, your answer can truthfully be "Baker's is economical."

Baker's is a complete food containing added carbohydrate, and adequate amounts of all known essential vitamins and minerals. Because Baker's is sold at an extremely low price, one ounce of formula costs less than a penny—about $1.50 per week for most infants.

Prescribe Baker's Modified Milk in the hospital and thus provide mothers with an economical, complete infant formula.

*Made exclusively from Grade A Milk (U. S. Public Health Service Milk Code)

**THE BAKER LABORATORIES, INC.**

*Milk Products Exclusively for the Medical Profession*

***Main Office:*** **Cleveland 3, Ohio** • ***Plant:*** **East Troy, Wisconsin**

the logical drug

to use first[1]

for petit mal epilepsy

# MILONTIN®

(phensuximide, Parke-Davis)

**KAPSEALS® and SUSPENSION**

**five years of study confirm[2]**

- effective in the petit mal triad
- one of the least toxic of all anti-epileptic drugs
- well tolerated

In patients with mixed grand mal—petit mal epilepsy, drug compatibility permits use of MILONTIN with Dilantin® Sodium (diphenylhydantoin sodium, Parke-Davis) or with Dilantin Sodium with Phenobarbital.

MILONTIN Kapseals, 0.5 Gm., bottles of 100 and 1,000; also available as MILONTIN Suspension (250 mg. per 4 cc.) in 16-ounce bottles.

Detailed information upon request, or from your Parke-Davis representative.

1. Davidson, D. T., Jr.; Lombroso, C., & Markham, C. H.: *New England J. Med.* 253:173, 1955.
2. Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955.

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

60028